CHAPTER 267

INSURANCE

HOUSE BILL 99-1306

BY REPRESENTATIVES Morrison, Alexander, Chavez, Clarke, Johnson, Leyba, Mitchell, Tochtrop, Witwer, Bacon, Coleman, Gotlieb, Grossman, Hagedorn, Keller, Lawrence, McElhany, Saliman, Takis, Tate, S. Williams, and Windels;
also SENATORS Wham, Epps, Linkhart, Matsunaka, Pascoe, Perlmutter, Reeves, and Rupert.

AN ACT

CONCERNING INDEPENDENT REVIEW FOR THE DENIAL OF BENEFITS UNDER A HEALTH INSURANCE PLAN, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-113 (3), Colorado Revised Statutes, is amended to read:

10-16-113. Procedure for denial of benefits. (3) (a) All denials of requests for reimbursement for medical treatment or other benefits on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient shall include an explanation of the specific medical basis for the denial and shall advise the covered person of the right to appeal such decision.

(b) (I) FOR THE PURPOSES OF THIS PARAGRAPH (b), A "HEALTH COVERAGE PLAN" DOES NOT INCLUDE INSURANCE ARISING OUT OF THE "WORKERS' COMPENSATION ACT OF COLORADO" OR OTHER SIMILAR LAW, AUTOMOBILE MEDICAL PAYMENT INSURANCE, PROPERTY AND CASUALTY INSURANCE , OR INSURANCE UNDER WHICH BENEFITS ARE PAYABLE WITH OR WITHOUT REGARD TO FAULT AND WHICH IS REQUIRED BY LAW TO BE CONTAINED IN ANY LIABILITY INSURANCE POLICY OR EQUIVALENT SELF-INSURANCE. A HEALTH COVERAGE PLAN SHALL SPECIFY THAT SUCH AN APPEAL WILL INCLUDE A TWO-LEVEL INTERNAL REVIEW OF THE DECISION, EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), FOLLOWED BY THE RIGHT OF THE COVERED PERSON TO REQUEST AN EXTERNAL REVIEW UNDER SECTION 10-16-113.5. THE COMMISSIONER SHALL PROMULGATE RULES SPECIFYING THE ELEMENTS OF AND TIMELINES FOR THESE APPEALS PROCEDURES, INCLUDING BUT NOT LIMITED TO THE REVIEW OF APPEALS REQUIRING EXPEDITED REVIEWS AND AUTHORIZATIONS BY THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW FOR ACCESS TO MEDICAL RECORDS NECESSARY FOR THE CONDUCT

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

OF THE EXTERNAL REVIEW. THE COMMISSIONER SHALL CONSULT WITH AND UTILIZE PUBLIC AND PRIVATE RESOURCES, INCLUDING BUT NOT LIMITED TO HEALTH CARE PROVIDERS, IN THE DEVELOPMENT OF SUCH RULES.

(II) THE FIRST-LEVEL APPEAL SHALL BE A REVIEW BY A PHYSICIAN WHO SHALL CONSULT WITH AN APPROPRIATE CLINICAL PEER OR PEERS IN THE SAME OR SIMILAR SPECIALTY AS WOULD TYPICALLY MANAGE THE CASE BEING REVIEWED. THE PHYSICIAN AND CLINICAL PEER OR PEERS SHALL NOT HAVE BEEN INVOLVED IN THE INITIAL DENIAL. HOWEVER, A PERSON THAT WAS PREVIOUSLY INVOLVED WITH THE DENIAL MAY ANSWER QUESTIONS. A HEALTH COVERAGE PLAN MAY ESTABLISH AN INTERNAL REVIEW PROCESS THAT ELIMINATES THE FIRST-LEVEL REVIEW AND WHEREBY ALL APPEALS ARE SENT DIRECTLY TO A REVIEW PANEL AS PROVIDED FOR IN THIS SUBPARAGRAPH (II).

(III) THE SECOND-LEVEL APPEAL SHALL BE TO A REVIEW PANEL ESTABLISHED BY THE HEALTH COVERAGE PLAN. THE PANEL SHALL INCLUDE A MINIMUM OF THREE PEOPLE. THE PANEL MAY BE COMPOSED OF EMPLOYEES OF THE HEALTH COVERAGE PLAN WHO HAVE APPROPRIATE PROFESSIONAL EXPERTISE. A MAJORITY OF THE PANEL SHALL BE COMPRISED OF PERSONS WHO WERE NOT PREVIOUSLY INVOLVED IN THE GRIEVANCE. HOWEVER, A PERSON WHO WAS PREVIOUSLY INVOLVED WITH THE GRIEVANCE MAY BE A MEMBER OF THE PANEL OR APPEAR BEFORE THE PANEL TO PRESENT INFORMATION OR ANSWER QUESTIONS. A HEALTH COVERAGE PLAN SHALL ENSURE THAT A MAJORITY OF THE PERSONS REVIEWING A GRIEVANCE INVOLVING AN ADVERSE DETERMINATION DO NOT HAVE A DIRECT FINANCIAL INTEREST IN THE CASE OR IN THE OUTCOME OF THE REVIEW. HOWEVER, SUCH PERSONS MAY BE PART OF THE HEALTH COVERAGE PLAN'S PROVIDER NETWORK OR EMPLOYEES OF THE HEALTH COVERAGE PLAN.

SECTION 2. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-113.5. Independent external review of benefit denials - legislative declaration - definitions. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT, IN THE INTEREST OF IMPROVING ACCOUNTABILITY FOR HEALTH CARE COVERAGE DECISIONS, COVERED INDIVIDUALS SHOULD HAVE THE OPTION OF AN INDEPENDENT EXTERNAL REVIEW BY QUALIFIED EXPERTS WHEN THEY HAVE BEEN DENIED A REQUEST FOR COVERAGE PURSUANT TO THEIR HEALTH PLAN'S PROCEDURES FOR DENIAL OF BENEFITS REQUIRED BY SECTION 10-16-113.

(2) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) (I) "COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW" MEANS A COVERED PERSON WHO:

(A) HAS GONE THROUGH EACH OF THE INTERNAL APPEALS REVIEW LEVELS OFFERED BY A HEALTH COVERAGE PLAN AND ESTABLISHED PURSUANT TO SECTION 10-16-113 (3) AND WHO HAS REQUESTED AN INDEPENDENT EXTERNAL REVIEW OF A HEALTH COVERAGE PLAN'S DECISION TO DENY REIMBURSEMENT FOR OR COVERAGE OF MEDICAL TREATMENT THAT IS A COVERED BENEFIT ON THE GROUNDS THAT SUCH TREATMENT IS NOT MEDICALLY NECESSARY, MEDICALLY APPROPRIATE, MEDICALLY EFFECTIVE, OR MEDICALLY EFFICIENT; OR

(B) HAS PURSUED AN EXPEDITED REVIEW OF A DENIAL OF A BENEFIT PURSUANT TO STATE REGULATION.

(II) THE TERM "COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW" SHALL ALSO INCLUDE THE DESIGNATED REPRESENTATIVE OF A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW.

(b) "EXPEDITED REVIEW" MEANS A REVIEW FOLLOWING COMPLETION OF PROCEDURES FOR EXPEDITED INTERNAL REVIEW OF AN ADVERSE DETERMINATION INVOLVING A SITUATION WHERE THE TIME FRAME OF THE STANDARD INDEPENDENT EXTERNAL REVIEW PROCEDURES WOULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN MAXIMUM FUNCTION.

(c) (I) "EXPERT REVIEWER" MEANS A PHYSICIAN OR OTHER APPROPRIATE HEALTH CARE PROVIDER ASSIGNED BY AN INDEPENDENT EXTERNAL REVIEW ENTITY TO CONDUCT AN INDEPENDENT EXTERNAL REVIEW. AN EXPERT REVIEWER SHALL NOT:

(A) HAVE BEEN INVOLVED IN THE COVERED INDIVIDUAL'S CARE PREVIOUSLY;

(B) BE A MEMBER OF THE BOARD OF DIRECTORS OF THE HEALTH COVERAGE PLAN;

(C) HAVE BEEN PREVIOUSLY INVOLVED IN THE REVIEW PROCESS FOR THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW;

(D) HAVE A DIRECT FINANCIAL INTEREST IN THE CASE OR IN THE OUTCOME OF THE REVIEW; OR

(E) BE AN EMPLOYEE OF THE HEALTH COVERAGE PLAN.

(II) PHYSICIANS OR OTHER APPROPRIATE HEALTH CARE PROVIDERS WHO ARE EXPERT REVIEWERS SHALL:

(A) BE EXPERTS IN THE TREATMENT OF THE MEDICAL CONDITION OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW AND KNOWLEDGEABLE ABOUT THE RECOMMENDED TREATMENT OR SERVICE THAT IS THE SUBJECT OF THE REVIEW THROUGH THE EXPERT'S ACTUAL, CURRENT CLINICAL EXPERIENCE;

(B) HOLD A LICENSE ISSUED BY A STATE AND, FOR PHYSICIANS, A CURRENT CERTIFICATION BY A RECOGNIZED AMERICAN MEDICAL SPECIALTY BOARD IN THE AREA APPROPRIATE TO THE SUBJECT OF REVIEW; AND

(C) HAVE NO HISTORY OF DISCIPLINARY ACTION OR SANCTION, INCLUDING LOSS OF STAFF PRIVILEGES OR PARTICIPATION RESTRICTIONS, TAKEN OR PENDING BY ANY HOSPITAL, GOVERNMENT, OR REGULATORY BODY.

(d) (I) "HEALTH COVERAGE PLAN" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (22.5).

(II) "HEALTH COVERAGE PLAN" DOES NOT INCLUDE INSURANCE ARISING OUT OF THE "WORKERS' COMPENSATION ACT OF COLORADO" OR OTHER SIMILAR LAW,

AUTOMOBILE MEDICAL PAYMENT INSURANCE, PROPERTY AND CASUALTY INSURANCE, OR INSURANCE UNDER WHICH BENEFITS ARE PAYABLE WITH OR WITHOUT REGARD TO FAULT AND WHICH IS REQUIRED BY LAW TO BE CONTAINED IN ANY LIABILITY INSURANCE POLICY OR EQUIVALENT SELF-INSURANCE.

(e) "INDEPENDENT EXTERNAL REVIEW ENTITY" MEANS AN ENTITY THAT MEETS THE REQUIREMENTS OF THIS SECTION AND IS CERTIFIED BY THE COMMISSIONER TO CONDUCT INDEPENDENT EXTERNAL REVIEWS OF DETERMINATIONS BY A PLAN TO DENY A REQUEST FOR REIMBURSEMENT FOR OR COVERAGE OF MEDICAL TREATMENT THAT IS A COVERED BENEFIT FOR A COVERED INDIVIDUAL ON THE GROUNDS THAT SUCH TREATMENT OR COVERED BENEFIT IS NOT MEDICALLY NECESSARY, MEDICALLY APPROPRIATE, MEDICALLY EFFECTIVE, OR MEDICALLY EFFICIENT. THE INDEPENDENT EXTERNAL REVIEW ENTITY MAY NOT REVIEW HEALTH COVERAGE PLAN DECISIONS TO DENY A REQUEST FOR REIMBURSEMENT FOR OR COVERAGE OF A MEDICAL TREATMENT THAT IS NOT A COVERED BENEFIT. THE INDEPENDENT EXTERNAL REVIEW ENTITY MAY REVIEW HEALTH CARE COVERAGE PLAN DECISIONS TO DENY A REQUEST FOR REIMBURSEMENT OR COVERAGE OF A MEDICAL TREATMENT ON THE GROUNDS THAT IT IS AN EXPERIMENTAL OR INVESTIGATIONAL PROCEDURE, BUT ONLY IF SUCH PROCEDURE IS NOT EXPLICITLY LISTED AS AN EXCLUDED BENEFIT IN THE POLICY. WHERE A SPECIFIC PROCEDURE IS A LISTED EXCLUDED BENEFIT, THE PLAN SHALL DENY COVERAGE ON THE GROUNDS THAT IT IS NOT A COVERED BENEFIT AND THIS SHALL NOT BE REVIEWABLE BY THE INDEPENDENT EXTERNAL REVIEW ENTITY.

(f) "MEDICAL AND SCIENTIFIC EVIDENCE" INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING SOURCES:

(I) PEER-REVIEWED SCIENTIFIC STUDIES PUBLISHED IN OR ACCEPTED FOR PUBLICATION BY MEDICAL JOURNALS THAT MEET NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS AND THAT SUBMIT MOST OF THEIR PUBLISHED ARTICLES FOR REVIEW BY EXPERTS WHO ARE NOT PART OF THE EDITORIAL STAFF;

(II) PEER-REVIEWED LITERATURE, BIOMEDICAL COMPENDIA, AND OTHER MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL INSTITUTE OF HEALTH'S NATIONAL LIBRARY OF MEDICINE FOR INDEXING IN INDEX MEDICUS, EXCERPTA MEDICUS ("EMBASE"), MEDLINE, AND MEDLARS DATA BASE OF HEALTH SERVICES TECHNOLOGY ASSESSMENT RESEARCH ("HSTAR");

(III) MEDICAL JOURNALS RECOGNIZED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, PURSUANT TO SECTION 1861 (t) (2) OF THE FEDERAL "SOCIAL SECURITY ACT";

(IV) THE FOLLOWING STANDARD REFERENCE COMPENDIA:

(A) THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG INFORMATION;

(B) THE AMERICAN MEDICAL ASSOCIATION DRUG EVALUATION;

(C) THE AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL THERAPEUTICS; AND

(D) THE UNITED STATES PHARMACOPOEIA - DRUG INFORMATION.

(V) FINDINGS, STUDIES, OR RESEARCH CONDUCTED BY OR UNDER THE AUSPICES OF FEDERAL GOVERNMENT AGENCIES AND NATIONALLY RECOGNIZED FEDERAL RESEARCH INSTITUTES, INCLUDING THE FEDERAL AGENCY FOR HEALTH CARE POLICY AND RESEARCH, NATIONAL INSTITUTES OF HEALTH, THE NATIONAL CANCER INSTITUTE, THE NATIONAL ACADEMY OF SCIENCES, THE HEALTH CARE FINANCING ADMINISTRATION, THE CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, AND THE NATIONAL BOARD RECOGNIZED BY THE NATIONAL INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL VALUE OF HEALTH SERVICES.

(3) HEALTH COVERAGE PLANS SHALL MAKE AVAILABLE AN INDEPENDENT EXTERNAL REVIEW PROCESS THAT MEETS THE REQUIREMENTS OF THIS SECTION. THE COST OF AN INDEPENDENT EXTERNAL REVIEW SHALL BE PAID BY THE HEALTH COVERAGE PLAN.

(4) (a) TO QUALIFY FOR CERTIFICATION BY THE COMMISSIONER AS AN INDEPENDENT EXTERNAL REVIEW ENTITY, SUCH ENTITY SHALL MEET THE FOLLOWING REQUIREMENTS:

(I) THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL ENSURE THAT CASES ARE REVIEWED BY EXPERT REVIEWERS KNOWLEDGEABLE ABOUT THE RECOMMENDED TREATMENT OR SERVICE THROUGH THE EXPERT REVIEWERS' ACTUAL, CURRENT CLINICAL EXPERIENCE AND WHO HAVE APPROPRIATE EXPERTISE IN THE SAME OR SIMILAR SPECIALTIES AS WOULD TYPICALLY MANAGE THE CASE BEING REVIEWED;

(II) THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL ENSURE THAT THE DECISION IS BASED UPON A CASE REVIEW THAT INCLUDES A REVIEW OF THE MEDICAL RECORDS OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW AND A REVIEW OF RELEVANT MEDICAL AND SCIENTIFIC EVIDENCE;

(III) THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL HAVE A QUALITY ASSURANCE PROCEDURE THAT ENSURES THE TIMELINESS AND QUALITY OF THE REVIEWS CONDUCTED PURSUANT TO THIS SECTION, THE QUALIFICATIONS AND INDEPENDENCE OF THE EXPERT REVIEWERS, AND THE CONFIDENTIALITY OF MEDICAL RECORDS AND REVIEW MATERIALS;

(IV) THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL MAINTAIN PATIENT CONFIDENTIALITY PURSUANT TO COLORADO AND FEDERAL LAW.

(b) IN ADDITION TO THE REQUIREMENTS SET FORTH IN PARAGRAPH (a) OF THIS SUBSECTION (4), THE COMMISSIONER SHALL ONLY CERTIFY AN INDEPENDENT EXTERNAL REVIEW ENTITY THAT:

(I) IS NOT A SUBSIDIARY OF, OR OWNED OR CONTROLLED BY, A CARRIER, TRADE ASSOCIATION OF CARRIERS, OR A PROFESSIONAL ASSOCIATION OF HEALTH CARE PROVIDERS;

(II) MAINTAINS DOCUMENTATION AVAILABLE FOR REVIEW BY THE DIVISION OF INSURANCE UPON REQUEST THAT SHALL INCLUDE THE FOLLOWING:

(A) THE NAMES OF ALL STOCKHOLDERS AND OWNERS OF MORE THAN FIVE PERCENT OF SUCH STOCK OR OPTIONS;

(B) THE NAMES OF ALL HOLDERS OF BONDS OR NOTES IN AMOUNTS IN EXCESS OF ONE HUNDRED THOUSAND DOLLARS;

(C) THE NAMES OF ALL CORPORATIONS AND ORGANIZATIONS THAT THE INDEPENDENT EXTERNAL REVIEW ENTITY CONTROLS OR IS AFFILIATED WITH, AND THE NATURE AND EXTENT OF ANY OWNERSHIP OR CONTROL, INCLUDING THE AFFILIATED ORGANIZATION'S BUSINESS ACTIVITIES;

(D) THE NAMES OF ALL DIRECTORS, OFFICERS, AND EXECUTIVES OF THE INDEPENDENT EXTERNAL REVIEW ENTITY AND A STATEMENT REGARDING ANY RELATIONSHIP THE DIRECTORS, OFFICERS, OR EXECUTIVES MAY HAVE WITH ANY HEALTH COVERAGE PLAN OR CARRIER.

(III) DOES NOT HAVE ANY MATERIAL PROFESSIONAL, FAMILY, OR FINANCIAL CONFLICT OF INTEREST WITH:

(A) THE HEALTH COVERAGE PLAN OR ANY OFFICER, DIRECTOR, OR EXECUTIVE OF THE HEALTH COVERAGE PLAN. THIS REQUIREMENT SHALL NOT PROHIBIT A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL WHO CONTRACTS WITH THE HEALTH COVERAGE PLAN AS A PARTICIPATING PROVIDER FROM SERVING ON A REVIEW PANEL OF THE INDEPENDENT EXTERNAL REVIEW ENTITY IF THE PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL MEETS THE REQUIREMENTS OF PARAGRAPH (c) OF SUBSECTION (2) OF THIS SECTION. IF A PARTICIPATING PROVIDER SERVES ON THE PANEL REVIEWING THE CASE OF A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW SHALL BE NOTIFIED THAT A HEALTH CARE PROFESSIONAL SERVING ON THE REVIEW PANEL HAS A CONTRACT AS A PARTICIPATING PROVIDER WITH THE HEALTH COVERAGE PLAN.

(B) THE PHYSICIAN OR PHYSICIAN'S MEDICAL GROUP THAT TREATED THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW;

(C) THE INSTITUTION AT WHICH THE TREATMENT OR SERVICE WOULD BE PROVIDED;

(D) THE DEVELOPMENT OR MANUFACTURE OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, TREATMENT, OR SERVICE PROPOSED FOR THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW WHOSE TREATMENT IS UNDER REVIEW; OR

(E) THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW.

(c) NOTHING IN SUBPARAGRAPH (III) OF PARAGRAPH (b) OF THIS SUBSECTION (4) SHALL BE CONSTRUED TO INCLUDE AFFILIATIONS THAT ARE LIMITED TO STAFF PRIVILEGES AT A HEALTH CARE INSTITUTION.

(d) THE COMMISSIONER SHALL PROMULGATE SUCH RULES AS ARE NECESSARY FOR THE CERTIFICATION OF INDEPENDENT EXTERNAL REVIEW ENTITIES UNDER THIS SECTION. THE COMMISSIONER MAY DENY, SUSPEND, OR REVOKE THE CERTIFICATION OF AN INDEPENDENT EXTERNAL REVIEW ENTITY THAT DOES NOT COMPLY WITH THE REQUIREMENTS OF THIS SECTION. THE COMMISSIONER SHALL HAVE THE AUTHORITY TO CONTRACT WITH ANY PERSON OR ENTITY TO DEVELOP THE CERTIFICATION RULES

AND FOR ADMINISTRATION OF THE CERTIFICATION PROGRAM. THE COMMISSIONER SHALL CONSULT WITH AND UTILIZE PUBLIC AND PRIVATE RESOURCES, INCLUDING BUT NOT LIMITED TO HEALTH CARE PROVIDERS, IN THE DEVELOPMENT OF SUCH RULES.

(5) UPON RECEIPT OF A REQUEST FROM A COVERED PERSON REQUESTING AN INDEPENDENT EXTERNAL REVIEW OF A DENIAL, THE HEALTH CARE COVERAGE PLAN SHALL CONTACT THE DIVISION OF INSURANCE. THE DIVISION OF INSURANCE OR ITS CONTRACTOR SHALL INFORM THE HEALTH CARE COVERAGE PLAN OF THE NAME OF THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY TO WHICH THE APPEAL SHOULD BE SENT.

(6) ALL HEALTH COVERAGE PLAN MATERIALS DEALING WITH THE PLAN'S GRIEVANCE PROCEDURES SHALL ADVISE COVERED PERSONS IN WRITING OF THE AVAILABILITY OF AN INDEPENDENT EXTERNAL REVIEW PROCESS, THE CIRCUMSTANCES UNDER WHICH A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW MAY USE THE INDEPENDENT EXTERNAL REVIEW PROCESS, THE PROCEDURES FOR REQUESTING AN INDEPENDENT EXTERNAL REVIEW, AND THE DEADLINES ASSOCIATED WITH AN INDEPENDENT EXTERNAL REVIEW.

(7) A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW SHALL MAKE SUCH REQUEST WITHIN SIXTY CALENDAR DAYS AFTER RECEIVING NOTIFICATION OF A SECOND-LEVEL APPEAL DENIAL OF COVERAGE FOR SUCH TREATMENT OR SERVICE. SUCH NOTIFICATION OF THE DENIAL OF COVERAGE SHALL INCLUDE A NOTIFICATION OF THE PERSON'S RIGHT TO AN INDEPENDENT EXTERNAL REVIEW. A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW SHALL NOTIFY THE PLAN IF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW REQUESTS AN EXPEDITED REVIEW.

(8) AFTER RECEIPT OF A WRITTEN REQUEST FOR AN INDEPENDENT EXTERNAL REVIEW, A HEALTH COVERAGE PLAN SHALL NOTIFY THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW IN WRITING. SUCH NOTIFICATION SHALL INCLUDE DESCRIPTIVE INFORMATION ON THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY THAT THE DIVISION OF INSURANCE OR ITS CONTRACTOR HAS SELECTED TO CONDUCT THE INDEPENDENT EXTERNAL REVIEW.

(9) (a) THE HEALTH COVERAGE PLAN SHALL PROVIDE TO THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY A COPY OF THE FOLLOWING DOCUMENTS AFTER THE DIVISION OF INSURANCE OR ITS CONTRACTOR HAS SELECTED A CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY FOR THE CASE:

(I) ANY INFORMATION SUBMITTED TO THE HEALTH COVERAGE PLAN BY A COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW OR THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OF THE COVERED INDIVIDUAL SEEKING AN INDEPENDENT EXTERNAL REVIEW IN SUPPORT OF THE REQUEST OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW FOR COVERAGE UNDER THE HEALTH COVERAGE PLAN'S PROCEDURES. THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY SHALL MAINTAIN THE CONFIDENTIALITY OF ANY MEDICAL RECORDS SUBMITTED PURSUANT TO THIS SUBSECTION (9).

(II) A COPY OF ANY RELEVANT DOCUMENTS USED BY THE PLAN TO DETERMINE THE MEDICAL NECESSITY, MEDICAL APPROPRIATENESS, MEDICAL EFFECTIVENESS, OR

MEDICAL EFFICIENCY OF THE PROPOSED SERVICE OR TREATMENT, AND A COPY OF ANY DENIAL LETTERS ISSUED BY THE PLAN CONCERNING THE INDIVIDUAL CASE UNDER REVIEW. THE HEALTH COVERAGE PLAN SHALL PROVIDE, UPON REQUEST TO THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, ALL RELEVANT INFORMATION SUPPLIED TO THE INDEPENDENT EXTERNAL REVIEW ENTITY THAT IS NOT CONFIDENTIAL OR PRIVILEGED UNDER STATE OR FEDERAL LAW CONCERNING THE INDIVIDUAL CASE UNDER REVIEW.

(b) THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY SHALL NOTIFY THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, AND THE HEALTH COVERAGE PLAN OF ANY ADDITIONAL MEDICAL INFORMATION REQUIRED TO CONDUCT THE REVIEW AFTER RECEIPT OF THE DOCUMENTATION REQUIRED PURSUANT TO THIS SECTION. THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW OR THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW SHALL SUBMIT THE ADDITIONAL INFORMATION, OR AN EXPLANATION OF WHY THE ADDITIONAL INFORMATION IS NOT BEING SUBMITTED, TO THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY AND THE HEALTH COVERAGE PLAN AFTER THE RECEIPT OF SUCH A REQUEST. THE HEALTH COVERAGE PLAN MAY, AT ITS DISCRETION, DETERMINE THAT ADDITIONAL INFORMATION PROVIDED BY THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW OR THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OF THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW JUSTIFIES A RECONSIDERATION OF ITS DENIAL OF COVERAGE, AND A SUBSEQUENT DECISION BY THE HEALTH COVERAGE PLAN TO PROVIDE COVERAGE SHALL TERMINATE THE INDEPENDENT EXTERNAL REVIEW UPON NOTIFICATION IN WRITING TO THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY AND THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW.

(10) (a) THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY SHALL SUBMIT THE EXPERT DETERMINATION TO THE HEALTH COVERAGE PLAN, THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW, AND THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW WITHIN THIRTY WORKING DAYS AFTER THE HEALTH COVERAGE PLAN HAS RECEIVED A REQUEST FOR EXTERNAL REVIEW; EXCEPT THAT, AT THE REQUEST OF THE EXPERT REVIEWER, SUCH DEADLINE SHALL BE EXTENDED BY UP TO TEN WORKING DAYS FOR THE CONSIDERATION OF ADDITIONAL INFORMATION REQUIRED PURSUANT TO THIS SECTION. IN THE CASE OF AN EXPEDITED REVIEW, THE DETERMINATIONS SHALL BE SUBMITTED WITHIN SEVEN WORKING DAYS AFTER THE HEALTH COVERAGE PLAN HAS RECEIVED A REQUEST FOR EXTERNAL REVIEW; EXCEPT THAT, AT THE REQUEST OF THE EXPERT REVIEWER, THE DEADLINE SHALL BE EXTENDED FOR FIVE WORKING DAYS FOR THE CONSIDERATION OF ADDITIONAL INFORMATION REQUIRED PURSUANT TO THIS SECTION.

(b) THE EXPERT REVIEWER'S DETERMINATION SHALL BE IN WRITING AND STATE THE REASONS THE REQUESTED TREATMENT OR SERVICE SHOULD OR SHOULD NOT BE COVERED. THE EXPERT REVIEWER'S DETERMINATIONS SHALL SPECIFICALLY CITE THE RELEVANT PROVISIONS IN THE HEALTH COVERAGE PLAN DOCUMENTATION, THE SPECIFIC MEDICAL CONDITION OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, AND THE RELEVANT DOCUMENTS PROVIDED

PURSUANT TO THIS SECTION TO SUPPORT THE EXPERT REVIEWER'S DETERMINATION. THE EXPERT REVIEWER'S DETERMINATION SHALL BE BASED ON AN OBJECTIVE REVIEW OF RELEVANT MEDICAL AND SCIENTIFIC EVIDENCE.

(c) DETERMINATIONS SHALL ALSO INCLUDE:

(I) THE TITLES AND QUALIFYING CREDENTIALS OF THE PERSONS CONDUCTING THE REVIEW;

(II) A STATEMENT OF THE UNDERSTANDING OF THE PERSONS CONDUCTING THE REVIEW OF THE NATURE OF THE GRIEVANCE AND ALL PERTINENT FACTS;

(III) THE RATIONALE FOR THE DECISION;

(IV) REFERENCE TO MEDICAL AND SCIENTIFIC EVIDENCE AND DOCUMENTATION CONSIDERED IN MAKING THE DETERMINATION; AND

(V) IN CASES INVOLVING A DETERMINATION ADVERSE TO THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, THE INSTRUCTIONS FOR REQUESTING A WRITTEN STATEMENT OF THE CLINICAL RATIONALE, INCLUDING THE CLINICAL REVIEW CRITERIA USED TO MAKE THE DETERMINATION.

(11) THE DETERMINATIONS OF THE EXPERT REVIEWER SHALL BE BINDING ON THE HEALTH COVERAGE PLAN AND ON THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW. A DETERMINATION OF THE EXPERT REVIEWER IN FAVOR OF THE COVERED INDIVIDUAL REQUESTING INDEPENDENT EXTERNAL REVIEW SHALL CREATE A REBUTTABLE PRESUMPTION IN ANY SUBSEQUENT ACTION THAT THE HEALTH COVERAGE PLAN'S COVERAGE DETERMINATION WAS NOT APPROPRIATE. A DETERMINATION OF THE EXPERT REVIEWER IN FAVOR OF THE HEALTH COVERAGE PLAN SHALL CREATE A REBUTTABLE PRESUMPTION IN ANY SUBSEQUENT ACTION THAT THE HEALTH COVERAGE PLAN'S COVERAGE DETERMINATION WAS APPROPRIATE.

(12) WHERE AN EXPERT DETERMINATION IS MADE IN FAVOR OF THE COVERED INDIVIDUAL REQUESTING AN INDEPENDENT EXTERNAL REVIEW, COVERAGE FOR THE TREATMENT AND SERVICES REQUIRED UNDER THIS SECTION SHALL BE PROVIDED SUBJECT TO THE TERMS AND CONDITIONS APPLICABLE TO BENEFITS UNDER THE HEALTH COVERAGE PLAN.

(13) A CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY AND AN EXPERT REVIEWER ASSIGNED BY SUCH INDEPENDENT EXTERNAL REVIEW ENTITY TO CONDUCT A REVIEW PURSUANT TO THIS SECTION SHALL BE IMMUNE FROM CIVIL LIABILITY IN ANY ACTION BROUGHT BY ANY PERSON BASED UPON THE DETERMINATIONS MADE PURSUANT TO THIS SECTION. THIS SUBSECTION (13) SHALL NOT APPLY TO AN ACT OR OMISSION OF THE INDEPENDENT EXTERNAL REVIEW ENTITY THAT IS MADE IN BAD FAITH OR INVOLVES GROSS NEGLIGENCE.

(14) NOTHING IN THIS SECTION SHALL MAKE THE HEALTH COVERAGE PLAN LIABLE FOR DAMAGES ARISING FROM ANY ACT OR OMISSION OF THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY.

(15) A HEALTH COVERAGE PLAN MAY REQUIRE A SURETY BOND TO INDEMNIFY THE

HEALTH COVERAGE PLAN FOR THE CERTIFIED INDEPENDENT EXTERNAL REVIEW ENTITY'S NONCOMPLIANCE WITH THIS SECTION.

SECTION 3. 10-3-1104 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(z) WILLFULLY VIOLATING ANY PROVISION OF SECTION 10-16-113.5.

SECTION 4. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the division of insurance cash fund not otherwise appropriated, to the department of regulatory agencies, for allocation to the division of insurance, for the fiscal year beginning July 1, 1999, the sum of seventeen thousand five hundred dollars ($17,500), or so much thereof as may be necessary, for the implementation of this act.

SECTION 5. Effective date - applicability. This section and sections 4 and 6 of this act shall take effect July 1, 1999, and the remainder of this act shall take effect June 1, 2000, and shall apply to denials of coverage made on or after said date.

SECTION 6. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 1, 1999