

# SENATE BILL No. 1208

April 12, 2000, Introduced by Senator SCHWARZ and referred to the Committee on Health Policy.

A bill to provide review of certain health care treatment adverse determinations; to provide for the review of review of health care coverage treatment adverse determinations by independent review organizations; to prescribe eligibility, powers, and duties of certain independent review organizations; to prescribe the powers and duties of certain health carriers; to prescribe the powers and duties of certain persons; to prescribe the powers and duties of certain state officials; to provide for the reporting of certain information; to provide fees; and to provide penalties for violations of this act.

## THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1       Sec. 1. This act shall be known and may be cited as the  
2 "patient's right to independent review act".

3       Sec. 3. As used in this act:

1 (a) "Adverse determination" means a determination by a  
2 health carrier or its designee utilization review organization  
3 that an admission, availability of care, continued stay, or other  
4 health care service that is a covered benefit has been reviewed  
5 and, based upon the information provided, does not meet the  
6 health carrier's requirements for medical necessity, appropriate-  
7 ness, health care setting, level of care, or effectiveness, and  
8 the requested service or payment for the service is therefore  
9 denied, reduced, or terminated.

10 (b) "Ambulatory review" means utilization review of health  
11 care services performed or provided in an outpatient setting.

12 (c) "Authorized representative" means any of the following:

13 (i) A person to whom a covered person has given express  
14 written consent to represent the covered person in an external  
15 review.

16 (ii) A person authorized by law to provide substituted con-  
17 sent for a covered person.

18 (iii) If the covered person is unable to provide consent, a  
19 family member of the covered person or the covered person's  
20 treating health care professional.

21 (d) "Case management" means a coordinated set of activities  
22 conducted for individual patient management of serious, compli-  
23 cated, protracted, or other health conditions.

24 (e) "Certification" means a determination by a health car-  
25 rier or its designee utilization review organization that an  
26 admission, availability of care, continued stay, or other health  
27 care service has been reviewed and, based on the information

1 provided, satisfies the health carrier's requirements for medical  
2 necessity, appropriateness, health care setting, level of care,  
3 and effectiveness.

4 (f) "Clinical review criteria" means the written screening  
5 procedures, decision abstracts, clinical protocols, and practice  
6 guidelines used by a health carrier to determine the necessity  
7 and appropriateness of health care services.

8 (g) "Commissioner" means the commissioner of the office of  
9 financial and insurance services.

10 (h) "Concurrent review" means utilization review conducted  
11 during a patient's hospital stay or course of treatment.

12 (i) "Covered benefits" or "benefits" means those health care  
13 services to which a covered person is entitled under the terms of  
14 a health benefit plan.

15 (j) "Covered person" means a policyholder, subscriber,  
16 member, enrollee, or other individual participating in a health  
17 benefit plan.

18 (k) "Discharge planning" means the formal process for deter-  
19 mining, prior to discharge from a facility, the coordination and  
20 management of the care that a patient receives following dis-  
21 charge from a facility.

22 (l) "Disclose" means to release, transfer, or otherwise  
23 divulge protected health information to any person other than the  
24 individual who is the subject of the protected health  
25 information.

26 (m) "Emergency medical condition" means the sudden onset of  
27 a medical condition that manifests itself by signs and symptoms

1 of sufficient severity, including severe pain, such that the  
2 absence of immediate medical attention could reasonably be  
3 expected to result in serious jeopardy to the individual's health  
4 or to a pregnancy in the case of a pregnant woman, impairment to  
5 bodily functions, or serious dysfunction of any bodily organ or  
6 part.

7 (n) "Expedited internal grievance" means an expedited griev-  
8 ance under section 2213(1)(m) of the insurance code of 1956, 1956  
9 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health  
10 care corporation reform act, 1980 PA 350, MCL 550.1404.

11 (o) "Facility" or "health facility" means:

12 (i) A facility or agency licensed or authorized under  
13 parts 201 to 217 of the public health code, 1978 PA 368,  
14 MCL 333.20101 to 333.21799e, or a licensed part thereof.

15 (ii) A mental hospital, psychiatric hospital, psychiatric  
16 unit, or mental retardation facility operated by the department  
17 of community health or certified or licensed under the mental  
18 health code, 1974 PA 258, MCL 330.1001 to 330.2106.

19 (iii) A facility providing outpatient physical therapy serv-  
20 ices, including speech pathology services.

21 (iv) A kidney disease treatment center, including a free-  
22 standing hemodialysis unit.

23 (v) An ambulatory health care facility.

24 (vi) A tertiary health care service facility.

25 (vii) A substance abuse treatment program licensed under  
26 parts 61 to 65 of the public health code, 1978 PA 368,  
27 MCL 333.6101 to 333.6523.

1       (viii) An outpatient psychiatric clinic.

2       (ix) A home health agency.

3       (p) "Health benefit plan" means a policy, contract, certifi-  
4 cate, or agreement offered or issued by a health carrier to pro-  
5 vide, deliver, arrange for, pay for, or reimburse any of the  
6 costs of health care services.

7       (q) "Health care professional" means a person licensed, cer-  
8 tified, or registered under parts 61 to 65 or 161 to 183 of the  
9 public health code, 1978 PA 368, MCL 333.6101 to 333.6523, and  
10 MCL 333.16101 to 333.18311.

11       (r) "Health care provider" or "provider" means a health care  
12 professional or a health facility.

13       (s) "Health care services" means services for the diagnosis,  
14 prevention, treatment, cure, or relief of a health condition,  
15 illness, injury, or disease.

16       (t) "Health carrier" means an entity subject to the insur-  
17 ance laws and regulations of this state, or subject to the juris-  
18 diction of the commissioner, that contracts or offers to contract  
19 to provide, deliver, arrange for, pay for, or reimburse any of  
20 the costs of health care services, including a sickness and acci-  
21 dent insurance company, a health maintenance organization, a non-  
22 profit health care corporation, or any other entity providing a  
23 plan of health insurance, health benefits, or health services.  
24 Health carrier does not include a state department or agency.

25       (u) "Health information" means information or data, whether  
26 oral or recorded in any form or medium, and personal facts or

1 information about events or relationships that relates to 1 or  
2 more of the following:

3       (i) The past, present, or future physical, mental, or behav-  
4 ioral health or condition of an individual or a member of the  
5 individual's family.

6       (ii) The provision of health care services to an  
7 individual.

8       (iii) Payment for the provision of health care services to  
9 an individual.

10       (v) "Independent review organization" means an entity that  
11 conducts independent external reviews of adverse determinations.

12       (w) "Prospective review" means utilization review conducted  
13 prior to an admission or a course of treatment.

14       (x) "Protected health information" means health information  
15 that identifies an individual who is the subject of the informa-  
16 tion or with respect to which there is a reasonable basis to  
17 believe that the information could be used to identify an  
18 individual.

19       (y) "Retrospective review" means a review of medical neces-  
20 sity conducted after services have been provided to a patient,  
21 but does not include the review of a claim that is limited to an  
22 evaluation of reimbursement levels, veracity of documentation,  
23 accuracy of coding, or adjudication for payment.

24       (z) "Second opinion" means an opportunity or requirement to  
25 obtain a clinical evaluation by a provider other than the one  
26 originally making a recommendation for a proposed health service

1 to assess the clinical necessity and appropriateness of the  
2 initial proposed health service.

3 (aa) "Utilization review" means a set of formal techniques  
4 designed to monitor the use of, or evaluate the clinical necessi-  
5 ty, appropriateness, efficacy, or efficiency of, health care  
6 services, procedures, or settings. Techniques may include ambu-  
7 latory review, prospective review, second opinion, certification,  
8 concurrent review, case management, discharge planning, or retro-  
9 spective review.

10 (bb) "Utilization review organization" means an entity that  
11 conducts utilization review, other than a health carrier perform-  
12 ing a review for its own health plans.

13 Sec. 5. (1) Except as otherwise provided in subsection (2),  
14 this act applies to all health carriers that provide or perform  
15 utilization review.

16 (2) This act does not apply to a policy or certificate that  
17 provides coverage only for a specified disease, specified acci-  
18 dent or accident-only coverage, credit, dental, disability  
19 income, hospital indemnity, long-term care insurance, vision care  
20 or any other limited supplemental benefit, medicare supplement  
21 policy of insurance, coverage under a plan through medicare, or  
22 the federal employees health benefits program, any coverage  
23 issued under chapter 55 of title 10 of the United States Code, 10  
24 U.S.C. 1071 to 1109, and any coverage issued as supplement to  
25 that coverage, any coverage issued as supplemental to liability  
26 insurance, worker's compensation or similar insurance, automobile  
27 medical-payment insurance, or any insurance under which benefits

1 are payable with or without regard to fault, whether written on a  
2 group blanket or individual basis.

3       Sec. 7. (1) A health carrier shall provide written notice  
4 to a covered person in plain English of the covered person's  
5 right to request an external review at the time the health car-  
6 rier sends written notice of an adverse determination.

7       (2) Except as provided in subsection (3)(a), a request for  
8 an external review under section 11 or 13 shall not be made until  
9 the covered person has exhausted the health carrier's internal  
10 grievance process provided for by law.

11       (3) The written notice of the right to request an external  
12 review shall include all of the following:

13       (a) For a notice related to an adverse determination, a  
14 statement informing the covered person of the following:

15       (i) If the covered person has a medical condition where the  
16 time frame for completion of an expedited internal grievance  
17 would seriously jeopardize the life or health of the covered  
18 person or would jeopardize the covered person's ability to regain  
19 maximum function, the covered person or the covered person's  
20 authorized representative may file a request for an expedited  
21 external review under section 13 at the same time the covered  
22 person or the covered person's authorized representative files a  
23 request for an expedited internal grievance subject to section  
24 13(3).

25       (ii) The covered person or the covered person's authorized  
26 representative may file a grievance under the health carrier's  
27 internal grievance process but if the health carrier has not



1 issued a written decision to the covered person or the covered  
2 person's authorized representative within 45 days following the  
3 date the covered person or the covered person's authorized repre-  
4 sentative files the grievance with the health carrier and the  
5 covered person or the covered person's authorized representative  
6 has not requested or agreed to a delay, the covered person or the  
7 covered person's authorized representative may file a request for  
8 external review under section 9 and shall be considered to have  
9 exhausted the health carrier's internal grievance process for  
10 purposes of subsection (2).

11 (b) A copy of the description of both the standard and expe-  
12 dited external review procedures the health carrier is required  
13 to provide under section 25, highlighting the provisions in the  
14 external review procedures that give the covered person or the  
15 covered person's authorized representative the opportunity to  
16 submit additional information and including any forms used to  
17 process an external review.

18 (c) As part of any forms provided under subdivision (b),  
19 include an authorization form, or other document approved by the  
20 commissioner, by which the covered person, for purposes of con-  
21 ducting an external review under this act, authorizes the health  
22 carrier to disclose protected health information, including medi-  
23 cal records, concerning the covered person that are pertinent to  
24 the external review.

25 Sec. 9. Except for a request for an expedited external  
26 review under section 13, all requests for external review shall  
27 be made in writing to the commissioner.

1       Sec. 11. (1) Not later than 60 days after the date of  
2 receipt of a notice of an adverse determination or final adverse  
3 determination under section 7, a covered person or the covered  
4 person's authorized representative may file a request for an  
5 external review with the commissioner. Upon receipt of a request  
6 for an external review, the commissioner immediately shall notify  
7 and send a copy of the request to the health carrier that made  
8 the adverse determination or final adverse determination that is  
9 the subject of the request.

10       (2) Not later than 5 business days after the date of receipt  
11 of a request for an external review, the commissioner shall com-  
12 plete a preliminary review of the request to determine all of the  
13 following:

14       (a) Whether the individual is or was a covered person in the  
15 health benefit plan at the time the health care service was  
16 requested or, in the case of a retrospective review, was a cov-  
17 ered person in the health benefit plan at the time the health  
18 care service was provided.

19       (b) Whether the health care service that is the subject of  
20 the adverse determination or final adverse determination reason-  
21 ably appears to be a covered service under the covered person's  
22 health benefit plan.

23       (c) Whether the covered person has exhausted the health  
24 carrier's internal grievance process unless the covered person is  
25 not required to exhaust the health carrier's internal grievance  
26 process under section 7(3)(a).

1 (d) The covered person has provided all the information and  
2 forms required by the commissioner that are necessary to process  
3 an external review, including the health information release  
4 form.

5 (3) Upon completion of the preliminary review under subsec-  
6 tion (2), the commissioner immediately shall notify in writing  
7 the covered person and, if applicable, the covered person's  
8 authorized representative as to whether the request is complete  
9 and whether it has been accepted for external review.

10 (4) If a request is accepted for external review, the com-  
11 missioner shall do both of the following:

12 (a) Include in the written notice under subsection (3) a  
13 statement that the covered person or the covered person's autho-  
14 rized representative may submit to the commissioner in writing  
15 within 7 days following the date of receipt of the notice addi-  
16 tional information and supporting documentation that the assigned  
17 independent review organization shall consider when conducting  
18 the external review.

19 (b) Immediately notify the health carrier in writing of the  
20 acceptance of the request for external review.

21 (5) If a request is not accepted for external review because  
22 the request is not complete, the commissioner shall inform the  
23 covered person and, if applicable, the covered person's autho-  
24 rized representative what information or materials are needed to  
25 make the request complete. If a request is not accepted for  
26 external review, the commissioner shall inform the covered  
27 person, if applicable, the covered person's authorized

1 representative, and the health carrier in writing of the reasons  
2 for its nonacceptance.

3       (6) At the time a request is accepted for external review,  
4 the commissioner shall assign an independent review organization  
5 that has been approved under this act to conduct the external  
6 review and provide a written recommendation to the commissioner  
7 on whether to uphold or reverse the adverse determination or the  
8 final adverse determination.

9       (7) In reaching a recommendation, the assigned independent  
10 review organization is not bound by any decisions or conclusions  
11 reached during the health carrier's utilization review process or  
12 the health carrier's internal grievance process.

13       (8) Not later than 7 business days after the date of receipt  
14 of the notice under subsection (4)(b), the health carrier or its  
15 designee utilization review organization shall provide to the  
16 assigned independent review organization the documents and any  
17 information considered in making the adverse determination or the  
18 final adverse determination. Except as provided in subsection  
19 (9), failure by the health carrier or its designee utilization  
20 review organization to provide the documents and information  
21 within 7 business days shall not delay the conduct of the exter-  
22 nal review.

23       (9) Upon receipt of a notice from the assigned independent  
24 review organization that the health carrier or its designee util-  
25 ization review organization has failed to provide the documents  
26 and information within 7 business days, the commissioner may  
27 terminate the external review and make a decision to reverse the

1 adverse determination or final adverse determination and shall  
2 immediately notify the assigned independent review organization,  
3 the covered person, if applicable, the covered person's autho-  
4 rized representative, and the health carrier of his or her  
5 decision.

6       (10) The assigned independent review organization shall  
7 review all of the information and documents received under sub-  
8 section (8) and any other information submitted in writing by the  
9 covered person or the covered person's authorized representative  
10 under subsection (4)(a) that has been forwarded to the indepen-  
11 dent review organization by the commissioner. Upon receipt of  
12 any information submitted by the covered person or the covered  
13 person's authorized representative under subsection (4)(a), at  
14 the same time the commissioner forwards the information to the  
15 independent review organization, the commissioner shall forward  
16 the information to the health carrier.

17       (11) Upon receipt of the information required to be for-  
18 warding under subsection (10), the health carrier may reconsider  
19 its adverse determination or final adverse determination that is  
20 the subject of the external review. Reconsideration by the  
21 health carrier of its adverse determination or final adverse  
22 determination does not delay or terminate the external review.  
23 The external review may only be terminated if the health carrier  
24 decides, upon completion of its reconsideration, to reverse its  
25 adverse determination or final adverse determination and provide  
26 coverage or payment for the health care service that is the  
27 subject of the adverse determination or final adverse

1 determination. Immediately upon making the decision to reverse  
2 its adverse determination or final adverse determination, the  
3 health carrier shall notify the covered person, if applicable,  
4 the covered person's authorized representative, the assigned  
5 independent review organization, and the commissioner in writing  
6 of its decision. The assigned independent review organization  
7 shall terminate the external review upon receipt of the notice  
8 from the health carrier.

9 (12) In addition to the documents and information provided  
10 under subsection (8), the assigned independent review organiza-  
11 tion, to the extent the information or documents are available  
12 and the independent review organization considers them appropri-  
13 ate, shall consider the following in reaching a recommendation:

14 (a) The covered person's pertinent medical records.

15 (b) The attending health care professional's  
16 recommendation.

17 (c) Consulting reports from appropriate health care profes-  
18 sionals and other documents submitted by the health carrier, the  
19 covered person, the covered person's authorized representative,  
20 or the covered person's treating provider.

21 (d) The terms of coverage under the covered person's health  
22 benefit plan with the health carrier.

23 (e) The most appropriate practice guidelines, which may  
24 include generally accepted practice guidelines, evidence-based  
25 practice guidelines, or any other practice guidelines developed  
26 by the federal government or national or professional medical  
27 societies, boards, and associations.

1 (f) Any applicable clinical review criteria developed and  
2 used by the health carrier or its designee utilization review  
3 organization.

4 (13) The assigned independent review organization shall pro-  
5 vide its recommendation to the commissioner not later than  
6 14 days after acceptance by the commissioner of the request for  
7 an external review. The independent review organization shall  
8 include in its recommendation all of the following:

9 (a) A general description of the reason for the request for  
10 external review.

11 (b) The date the independent review organization received  
12 the assignment from the commissioner to conduct the external  
13 review.

14 (c) The date the external review was conducted.

15 (d) The date of its recommendation.

16 (e) The principal reason or reasons for its recommendation.

17 (f) The rationale for its recommendation.

18 (g) References to the evidence or documentation, including  
19 the practice guidelines, considered in reaching its  
20 recommendation.

21 (14) Upon receipt of the assigned independent review  
22 organization's recommendation under subsection (13), the commis-  
23 sioner immediately shall review the recommendation to ensure that  
24 it is not contrary to the terms of coverage under the covered  
25 person's health benefit plan with the health carrier.

26 (15) The commissioner shall notify the covered person, if  
27 applicable, the covered person's authorized representative, and

1 the health carrier in writing of the decision to uphold or  
2 reverse the adverse determination or the final adverse determina-  
3 tion not later than 14 days after the date of receipt of the  
4 selected independent review organization's recommendation. The  
5 commissioner shall include in this notice all of the following:

6 (a) The principal reason or reasons for the decision,  
7 including, as an attachment to the notice or in any other manner  
8 the commissioner considers appropriate, the information provided  
9 by the selected independent review organization under subsection  
10 (13).

11 (b) If appropriate, the principal reason or reasons why the  
12 commissioner did not follow the assigned independent review  
13 organization's recommendation.

14 (16) Upon receipt of a notice of a decision under subsection  
15 (15) reversing the adverse determination or final adverse deter-  
16 mination, the health carrier immediately shall approve the cover-  
17 age that was the subject of the adverse determination or final  
18 adverse determination.

19 Sec. 13. (1) Except as provided in subsection (11), a cov-  
20 ered person or the covered person's authorized representative may  
21 make a request for an expedited external review with the commis-  
22 sioner at the time the covered person receives an adverse deter-  
23 mination if both of the following are met:

24 (a) The adverse determination involves a medical condition  
25 of the covered person for which the time frame for completion of  
26 an expedited internal grievance would seriously jeopardize the



1 life or health of the covered person or would jeopardize the  
2 covered person's ability to regain maximum function.

3 (b) The covered person or the covered person's authorized  
4 representative has filed a request for an expedited internal  
5 grievance.

6 (2) At the time the commissioner receives a request for an  
7 expedited external review, the commissioner immediately shall  
8 notify and provide a copy of the request to the health carrier  
9 that made the adverse determination or final adverse determina-  
10 tion that is the subject of the request and for a request that  
11 the commissioner has determined meets the reviewability require-  
12 ments under section 11(2), assign an independent review organiza-  
13 tion that has been approved under this act to conduct the expe-  
14 dited external review, and provide a written recommendation to  
15 the commissioner on whether to uphold or reverse the adverse  
16 determination or final adverse determination.

17 (3) If a covered person has not completed the health  
18 carrier's expedited internal grievance process, the independent  
19 review organization shall determine immediately after receipt of  
20 the assignment to conduct the expedited external review whether  
21 the covered person will be required to complete the expedited  
22 internal grievance prior to conducting the expedited external  
23 review. If the independent review organization determines that  
24 the covered person must first complete the expedited internal  
25 grievance process, the independent review organization immedi-  
26 ately shall notify the covered person and, if applicable, the  
27 covered person's authorized representative of this determination

1 and that it will not proceed with the expedited external review  
2 until the covered person completes the expedited internal  
3 grievance.

4       (4) In reaching a recommendation, the assigned independent  
5 review organization is not bound by any decisions or conclusions  
6 reached during the health carrier's utilization review process or  
7 the health carrier's internal grievance process.

8       (5) Not later than 12 hours after the health carrier  
9 receives the notice under subsection (2), the health carrier or  
10 its designee utilization review organization shall provide or  
11 transmit all necessary documents and information considered in  
12 making the adverse determination or final adverse determination  
13 to the assigned independent review organization electronically or  
14 by telephone or facsimile or any other available expeditious  
15 method.

16       (6) In addition to the documents and information provided or  
17 transmitted under subsection (5), the assigned independent review  
18 organization, to the extent the information or documents are  
19 available and the independent review organization considers them  
20 appropriate, shall consider the following in reaching a  
21 recommendation:

22       (a) The covered person's pertinent medical records.

23       (b) The attending health care professional's  
24 recommendation.

25       (c) Consulting reports from appropriate health care profes-  
26 sionals and other documents submitted by the health carrier,

1 covered person, the covered person's authorized representative,  
2 or the covered person's treating provider.

3 (d) The terms of coverage under the covered person's health  
4 benefit plan with the health carrier.

5 (e) The most appropriate practice guidelines, which may  
6 include generally accepted practice guidelines, evidence-based  
7 practice guidelines, or any other practice guidelines developed  
8 by the federal government or national or professional medical  
9 societies, boards, and associations.

10 (f) Any applicable clinical review criteria developed and  
11 used by the health carrier or its designee utilization review  
12 organization in making adverse determinations.

13 (7) The assigned independent review organization shall pro-  
14 vide its recommendation to the commissioner as expeditiously as  
15 the covered person's medical condition or circumstances require,  
16 but in no event more than 36 hours after the date the commis-  
17 sioner received the request for an expedited external review.

18 (8) Upon receipt of the assigned independent review  
19 organization's recommendation, the commissioner immediately shall  
20 review the recommendation to ensure that it is not contrary to  
21 the terms of coverage under the covered person's health benefit  
22 plan with the health carrier.

23 (9) As expeditiously as the covered person's medical condi-  
24 tion or circumstances require, but in no event more than 24 hours  
25 after receiving the recommendation of the assigned independent  
26 review organization, the commissioner shall complete the review  
27 of the independent review organization's recommendation and

1 notify the covered person, if applicable, the covered person's  
2 authorized representative, and the health carrier of the decision  
3 to uphold or reverse the adverse determination or final adverse  
4 determination. If this notice was not in writing, within 2 days  
5 after the date of providing that notice, the commissioner shall  
6 provide written confirmation of the decision to the covered  
7 person, if applicable, the covered person's authorized represen-  
8 tative, and the health carrier and include the information  
9 required in section 11(15).

10 (10) Upon receipt of a notice of a decision under subsection  
11 (9) reversing the adverse determination or final adverse determi-  
12 nation, the health carrier immediately shall approve the coverage  
13 that was the subject of the adverse determination or final  
14 adverse determination.

15 (11) An expedited external review shall not be provided for  
16 retrospective adverse determinations or retrospective final  
17 adverse determinations.

18 Sec. 15. (1) An external review decision is binding on the  
19 health carrier except to the extent the health carrier has other  
20 remedies available under applicable state law.

21 (2) An external review decision is binding on the covered  
22 person except to the extent the covered person has other remedies  
23 available under applicable federal or state law.

24 (3) A covered person or the covered person's authorized rep-  
25 resentative may not file a subsequent request for external review  
26 involving the same adverse determination or final adverse

1 determination for which the covered person has already received  
2 an external review decision under this act.

3       Sec. 17. (1) The commissioner shall approve independent  
4 review organizations eligible to be assigned to conduct external  
5 reviews under this act to ensure that an independent review  
6 organization satisfies the minimum standards established under  
7 section 19.

8       (2) The commissioner shall develop an application form for  
9 initially approving and for reapproving independent review organ-  
10 izations to conduct external reviews.

11       (3) Any independent review organization wishing to be  
12 approved to conduct external reviews under this act shall submit  
13 the application form developed under subsection (2) and include  
14 with the form all documentation and information necessary for the  
15 commissioner to determine if the independent review organization  
16 satisfies the minimum qualifications established under section  
17 19. The commissioner may charge an application fee that indepen-  
18 dent review organizations shall submit to the commissioner with  
19 an application for approval and reapproval.

20       (4) An approval under this section is effective for 2 years,  
21 unless the commissioner determines before expiration of the  
22 approval that the independent review organization is not satisfy-  
23 ing the minimum standards established under section 19. If the  
24 commissioner determines that an independent review organization  
25 no longer satisfies the minimum standards established under sec-  
26 tion 19, the commissioner shall terminate the approval of the  
27 independent review organization and remove the independent review

1 organization from the list of independent review organizations  
2 approved to conduct external reviews under this act that is main-  
3 tained by the commissioner under subsection (5).

4 (5) The commissioner shall maintain and periodically update  
5 a list of approved independent review organizations.

6 Sec. 19. (1) To be approved under section 17 to conduct  
7 external reviews, an independent review organization shall do  
8 both of the following:

9 (a) Have and maintain written policies and procedures that  
10 govern all aspects of both the standard external review process  
11 and the expedited external review process under sections 11 and  
12 13 that include, at a minimum, a quality assurance mechanism in  
13 place that does all of the following:

14 (i) Ensures that external reviews are conducted within the  
15 specified time frames and required notices are provided in a  
16 timely manner.

17 (ii) Ensures the selection of qualified and impartial clini-  
18 cal peer reviewers to conduct external reviews on behalf of the  
19 independent review organization and suitable matching of review-  
20 ers to specific cases.

21 (iii) Ensures the confidentiality of medical and treatment  
22 records and clinical review criteria.

23 (iv) Ensures that any person employed by or under contract  
24 with the independent review organization adheres to the require-  
25 ments of this act.

26 (b) Agree to maintain and provide to the commissioner the  
27 information required in section 23.

1       (2) A clinical peer reviewer assigned by an independent  
2 review organization to conduct external reviews shall be a physi-  
3 cian or other appropriate health care professional who meets all  
4 of the following minimum qualifications:

5       (a) Is an expert in the treatment of the covered person's  
6 medical condition that is the subject of the external review.

7       (b) Is knowledgeable about the recommended health care serv-  
8 ice or treatment through recent or current actual clinical  
9 experience treating patients with the same or similar medical  
10 condition of the covered person.

11       (c) Holds a nonrestricted license in a state of the United  
12 States and, for physicians, a current certification by a recog-  
13 nized American medical specialty board in the area or areas  
14 appropriate to the subject of the external review.

15       (d) Has no history of disciplinary actions or sanctions,  
16 including loss of staff privileges or participation restrictions,  
17 that have been taken or are pending by any hospital, governmental  
18 agency or unit, or regulatory body that raise a substantial ques-  
19 tion as to the clinical peer reviewer's physical, mental, or pro-  
20 fessional competence or moral character.

21       (3) An independent review organization may not own or con-  
22 trol, be a subsidiary of or in any way be owned or controlled by,  
23 or exercise control with a health benefit plan, a national,  
24 state, or local trade association of health benefit plans, or a  
25 national, state, or local trade association of health care  
26 providers.

1       (4) An independent review organization selected to conduct  
2 the external review and any clinical peer reviewer assigned by  
3 the independent organization to conduct the external review shall  
4 not have a material professional, familial, or financial conflict  
5 of interest with any of the following:

6       (a) The health carrier that is the subject of the external  
7 review.

8       (b) The covered person whose treatment is the subject of the  
9 external review or the covered person's authorized  
10 representative.

11       (c) Any officer, director, or management employee of the  
12 health carrier that is the subject of the external review.

13       (d) The health care provider, the health care provider's  
14 medical group, or independent practice association recommending  
15 the health care service or treatment that is the subject of the  
16 external review.

17       (e) The facility at which the recommended health care serv-  
18 ice or treatment would be provided.

19       (f) The developer or manufacturer of the principal drug,  
20 device, procedure, or other therapy being recommended for the  
21 covered person whose treatment is the subject of the external  
22 review.

23       (5) In determining whether an independent review organiza-  
24 tion or a clinical peer reviewer of the independent review organ-  
25 ization has a material professional, familial, or financial con-  
26 flict of interest for purposes of subsection (4), the  
27 commissioner shall take into consideration situations where the



1 independent review organization to be assigned to conduct an  
2 external review of a specified case or a clinical peer reviewer  
3 to be assigned by the independent review organization to conduct  
4 an external review of a specified case may have an apparent pro-  
5 fessional, familial, or financial relationship or connection with  
6 a person described in subsection (4), but that the characteris-  
7 tics of that relationship or connection are such that they are  
8 not a material professional, familial, or financial conflict of  
9 interest that results in the disapproval of the independent  
10 review organization or the clinical peer reviewer from conducting  
11 the external review.

12       Sec. 21. An independent review organization or clinical  
13 peer reviewer working on behalf of an independent review organi-  
14 zation is not liable in damages to any person for any opinions  
15 rendered during or upon completion of an external review con-  
16 ducted under this act, unless the opinion was rendered in bad  
17 faith or involved gross negligence.

18       Sec. 23. (1) An independent review organization assigned to  
19 conduct an external review under section 11 or 13 shall maintain  
20 for 3 years written records in the aggregate and by health car-  
21 rier on all requests for external review for which it conducted  
22 an external review during a calendar year. Each independent  
23 review organization required to maintain written records on all  
24 requests for external review for which it was assigned to conduct  
25 an external review shall submit to the commissioner, at least  
26 annually, a report in the format specified by the commissioner.

1       (2) The report to the commissioner under subsection (1)  
2 shall include in the aggregate and for each health carrier all of  
3 the following:

4       (a) The total number of requests for external review.

5       (b) The number of requests for external review resolved and,  
6 of those resolved, the number resolved upholding the adverse  
7 determination or final adverse determination and the number  
8 resolved reversing the adverse determination or final adverse  
9 determination.

10      (c) The average length of time for resolution.

11      (d) A summary of the types of coverages or cases for which  
12 an external review was sought, as provided in the format required  
13 by the commissioner.

14      (e) The number of external reviews under section 11(11) that  
15 were terminated as the result of a reconsideration by the health  
16 carrier of its adverse determination or final adverse determina-  
17 tion after the receipt of additional information from the covered  
18 person or the covered person's authorized representative.

19      (f) Any other information the commissioner may request or  
20 require.

21      (3) Each health carrier shall maintain for 3 years written  
22 records in the aggregate and for each type of health benefit plan  
23 offered by the health carrier on all requests for external review  
24 that are filed with the health carrier or that the health carrier  
25 receives notice of from the commissioner under this act. Each  
26 health carrier required to maintain written records on all  
27 requests for external review shall submit to the commissioner, at

1 least annually, a report in the format specified by the  
2 commissioner.

3 (4) The report to the commissioner under subsection (3)  
4 shall include in the aggregate and by type of health benefit plan  
5 all of the following:

6 (a) The total number of requests for external review.

7 (b) From the number of requests for external review that are  
8 filed directly with the health carrier, the number of requests  
9 accepted for a full external review.

10 (c) The number of requests for external review resolved and,  
11 of those resolved, the number resolved upholding the adverse  
12 determination or final adverse determination and the number  
13 resolved reversing the adverse determination or final adverse  
14 determination.

15 (d) The average length of time for resolution.

16 (e) A summary of the types of coverages or cases for which  
17 an external review was sought, as provided in the format required  
18 by the commissioner.

19 (f) The number of external reviews under section 11(11) that  
20 were terminated as the result of a reconsideration by the health  
21 carrier of its adverse determination or final adverse determina-  
22 tion after the receipt of additional information from the covered  
23 person or the covered person's authorized representative.

24 (g) Any other information the commissioner may request or  
25 require.

26 Sec. 25. (1) Each health carrier shall include a  
27 description of the external review procedures in or attached to

1 the policy, certificate, membership booklet, outline of coverage,  
2 or other evidence of coverage it provides to covered persons.

3 (2) The description under subsection (1) shall include all  
4 of the following:

5 (a) A statement that informs the covered person of the right  
6 of the covered person to file a request for an external review of  
7 an adverse determination or final adverse determination with the  
8 commissioner.

9 (b) The telephone number and address of the commissioner.

10 (c) A statement informing the covered person that, when  
11 filing a request for an external review, the covered person will  
12 be required to authorize the release of any medical records of  
13 the covered person that may be required to be reviewed for the  
14 purpose of reaching a decision on the external review.

15 Sec. 27. The commissioner may promulgate rules pursuant to  
16 the administrative procedures act of 1969, 1969 PA 306,  
17 MCL 24.201 to 24.328, necessary to carry out the provisions of  
18 this act.

19 Sec. 29. (1) Any person who violates any provision of this  
20 act may request a hearing before the commissioner pursuant to the  
21 administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to  
22 24.328. If the commissioner finds that a violation has occurred,  
23 the commissioner shall reduce the findings and decision to writ-  
24 ing and shall issue and cause to be served upon the person  
25 charged with the violation a copy of the findings and an order  
26 requiring the person to cease and desist from the violation. In  
27 addition, the commissioner may order any of the following:

1       (a) Payment of a civil fine of not more than \$500.00 for  
2 each violation. However, if the person knew or reasonably should  
3 have known that he or she was in violation of this act, the com-  
4 missioner may order the payment of a civil fine of not more than  
5 \$2,500.00 for each violation. An order of the commissioner under  
6 this subdivision shall not require the payment of civil fines  
7 exceeding \$25,000.00. A fine collected under this subdivision  
8 shall be turned over to the state treasurer and credited to the  
9 general fund.

10       (b) The suspension, limitation, or revocation of the  
11 person's license or certificate of authority.

12       (2) After notice and opportunity for hearing, the commis-  
13 sioner may by order reopen and alter, modify, or set aside, in  
14 whole or in part, an order issued under this section if, in the  
15 commissioner's opinion, conditions of fact or law have changed to  
16 require that action or the public interest requires that action.

17       (3) If a person knowingly violates a cease and desist order  
18 under this section and has been given notice and an opportunity  
19 for a hearing held pursuant to the administrative procedures act  
20 of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner may  
21 order a civil fine of \$10,000.00 for each violation, or a suspen-  
22 sion, limitation, or revocation of a person's license, or both.  
23 A fine collected under this subsection shall be turned over to  
24 the state treasurer and credited to the general fund.

1       (4) The commissioner may apply to the Ingham county circuit  
2 court for an order of the court enjoining a violation of this  
3 act.

4       Enacting section 1. This act takes effect October 1, 2000.