REFERENCE TITLE: insurance; health care appeals; medications

State of Arizona
House of Representatives
Fifty-third Legislature
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2017

HB 2471

Introduced by
Representative Livingston

AN ACT

AMENDING SECTIONS 20-2501, 20-2530, 20-2532, 20-2533, 20-2534, 20-2535, 20-2536, 20-2537 AND 20-2541, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 15, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2542 AND 20-2543; RELATING TO HEALTH CARE APPEALS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-2501, Arizona Revised Statutes, is amended to read:

20-2501. Definitions; scope

A. In this chapter, unless the context otherwise requires:

1. "Adverse ~~decision~~ DETERMINATION" means a utilization review determination by the utilization review agent that a requested service or claim for service, IN WHOLE OR IN PART, OR A DENIAL, REDUCTION OR TERMINATION OF A SERVICE, is not a covered service or is not medically necessary under the plan if that determination results in a documented denial or nonpayment of the service or claim. ADVERSE DETERMINATION INCLUDES A RESCISSION OF COVERAGE.

2. "Benefits based on the health status of the insured" means a contract of insurance to pay a fixed benefit amount, without regard to the specific services received, to a policyholder who meets certain eligibility criteria based on health status including:

(a) A disability income insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is deemed ~~a person with~~ TO HAVE a disability as defined by the policy terms.

(b) A hospital indemnity policy that pays a fixed daily benefit during hospital confinement.

(c) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is certified by a licensed health care professional as chronically ill as defined by the policy terms.

(d) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who suffers from a prolonged physical illness, disability or cognitive disorder as defined by the policy terms.

3. "Claim" means a request for payment for a service already provided. Claim does not include:

(a) Claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers.

(b) A request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

4. "Covered service" means a service that is included in a policy, evidence of coverage or similar document that specifies which services, insurance or other benefits are included or covered.

5. "Denial" means a direct or indirect determination regarding all or part of a request for any service, INCLUDING A DENIAL, REDUCTION OR TERMINATION OF A SERVICE OR A RESCISSION OF COVERAGE, or a direct determination regarding a claim that may trigger a request for review ~~or reconsideration~~. Denial does not include:

(a) Enforcement of a health care insurer's deductibles, copayments or coinsurance requirements or adjustments for usual and customary charges, deductibles, copayments or coinsurance requirements for a service or coordination of benefits between health care insurers.

(b) The rejection of a request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

6. "Department" means the department of insurance.

7. "Director" means the director of the department of insurance.

8. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, prepaid dental plan organization, medical service corporation, dental service corporation or optometric service corporation or a hospital, medical, dental and optometric service corporation.

9. "Indirect denial" means a failure to communicate authorization or nonauthorization to the member by the utilization review agent within ten business days after the utilization review agent receives the request for a covered service.

10. "INTERNAL LEVELS OF REVIEW" MEANS AN EXPEDITED MEDICAL REVIEW AND EXPEDITED APPEAL PURSUANT TO SECTION 20-2534, AN INITIAL APPEAL PURSUANT TO SECTION 20-2535 AND, IF APPLICABLE, A VOLUNTARY INTERNAL APPEAL PURSUANT TO SECTION 20-2536.

~~10.~~ 11. "Provider" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for providing care, treatment and services rendered to a patient.

~~11.~~ 12. "Service" means a diagnostic or therapeutic medical or health care service, benefit or treatment.

~~12.~~ 13. "Utilization review" means a system for reviewing the appropriate and efficient allocation of inpatient hospital resources, inpatient medical services and outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and health care services or claims for services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services. Utilization review does not include elective requests for the clarification of coverage.

~~13.~~ 14. "Utilization review agent" means a person or entity that performs utilization review. For purposes of article 2 of this chapter, utilization review agent has the same meaning prescribed in section 20-2530. For purposes of this chapter, utilization review agent does not include:

(a) A governmental agency.
(b) An agent that acts on behalf of the governmental agency.
(c) An employee of a utilization review agent.
~~14.~~ 15. "Utilization review plan" means a summary description of the utilization review guidelines, protocols, procedures and written standards and criteria of a utilization review agent.
B. For the purposes of this chapter, utilization review by an optometric service corporation applies only to nonsurgical medical and health care services.
Sec. 2. Section 20-2530, Arizona Revised Statutes, is amended to read:
20-2530. Definitions
For the purposes of this article:
1. "FINAL ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMINATION UPHELD, IN WHOLE OR IN PART, AT THE COMPLETION OF THE HEALTH CARE INSURER'S INTERNAL LEVELS OF REVIEW OR AN ADVERSE DETERMINATION WITH RESPECT TO WHICH THE INTERNAL LEVELS OF REVIEW HAVE BEEN EXHAUSTED.
~~1.~~ 2. "Member" means a person who is covered under a health care plan provided by a health care insurer or that person's treating provider, parent, legal guardian, surrogate who is authorized to make health care decisions for that person by a power of attorney, a court order or the provisions of section 36-3231, or agent who is an adult and who has the authority to make health care treatment decisions for that person pursuant to a health care power of attorney.
~~2.~~ 3. "Utilization review agent" means those persons and entities that perform utilization review as defined in section 20-2501 and includes any health care insurer whose utilization review plan includes the direct or indirect denial of requested medical or health care services or the denial of claims.
Sec. 3. Section 20-2532, Arizona Revised Statutes, is amended to read:
20-2532. Utilization review standards and criteria; requirements
A. Each utilization review agent shall:
1. Adopt a written utilization review plan with standards and criteria that apply to all utilization review ~~decisions~~ DETERMINATIONS and that are objective, clinically valid and compatible with established principles of health care.
2. Establish the utilization review plan with input from physician advisors who represent major medical specialties and who are certified or board eligible under the standards of the appropriate American medical specialty board.
3. Include in the adopted utilization review plan a process for prompt initial reconsideration of an adverse ~~decision~~ DETERMINATION and a process for appeals that meet the requirements of this article. This

paragraph does not apply to utilization review activities limited to retrospective claims review.

B. Deviations from the written standards and criteria in the utilization review plan are permitted if the utilization review agent determines that the member and other members with similar symptoms and diagnoses would materially benefit from new treatments available because of medical or technological advances made since the adoption of the utilization review plan and made in accordance with accepted medical standards. This subsection does not apply to utilization review activities limited to retrospective claims review. Nothing in this subsection creates a private right or cause of action against a health care insurer or utilization review agent for failure to deviate from the utilization review plan.

C. A health care insurer who utilizes the services of an outside utilization review agent shall adopt a utilization review plan pursuant to subsections A and B of this section. The utilization review plan adopted and filed by the health care insurer who utilizes the services of an outside utilization review agent is deemed adopted by that utilization review agent.

D. A health care insurer who utilizes the services of an outside utilization review agent is responsible for the utilization review agent's acts that are within the scope of the written and filed utilization review plan, including the administration of all patient claims processed by the utilization review agent on behalf of the health care insurer.

E. Notwithstanding section 20-2502, subsection B, each utilization review agent shall file a notice with the director that provides a specific description and the published date of the source of the written standards and criteria of the utilization review plan and that certifies that the utilization review plan in use complies with the requirements of this section, is available for review and inspection at a designated location in this state or at an office accessible to authorized representatives of the director in another state and is the complete utilization review plan with all standards and criteria on which utilization review decisions are based. A copy of any portion of the utilization review plan on which any adverse ~~decisions~~ DETERMINATIONS have been based shall be made before the effective date of any modification and the utilization review agent shall retain a copy at the designated location for review and inspection for a period of five years after the date of the modification. If at any time a complete change in the written standards and criteria occurs, the utilization review agent shall file a new certification notice with the director.

F. On or before March 1 of each year after the year in which the utilization review agent filed the notice prescribed in subsection E of this section, the utilization review agent or the agent's successor shall submit a signed and notarized annual report to the director that includes

the designated location for review and inspection by the director or the director's authorized representative and that certifies that:

1. The utilization review plan and all modifications remain in compliance with the requirements of this section.

2. The utilization review agent will conduct all utilization reviews in accordance with the plan.

3. All adverse ~~decisions~~ DETERMINATIONS made in the prior year were based on the plan in effect on the date of those ~~decisions~~ DETERMINATIONS.

G. On written request, the utilization review agent shall provide copies to any member or the member's treating provider of:

1. Those portions of the utilization review agent's utilization review plan that are relevant to the request for a covered service or claim for a covered service.

2. The protocols or guidelines that were used if the standards and criteria adopted are based on protocols or guidelines developed by an American medical specialty board.

H. Any person who requests records pursuant to subsection G of this section shall direct the request to the utilization review agent and not to the department.

I. If the utilization review plan is copyrighted by a person other than the utilization review agent, the health care insurer shall make a good faith effort to obtain permission from that person to make copies of the relevant material. If the health care insurer is unable to secure copyright permission, the utilization review agent shall provide a detailed summary of the relevant portions of the utilization review plan.

J. Health care insurers having utilization review activities limited to retrospective claims review shall be required to adopt only those procedures and sources of review that are traditionally associated with and necessary for retrospective claims review.

Sec. 4. Section 20-2533, Arizona Revised Statutes, is amended to read:

20-2533. Denial; levels of review; disclosure; additional time after service by mail; review process

A. Any member who is denied a covered service or whose claim for a service is denied may pursue the applicable review process prescribed in this article. Except as provided in sections 20-2534 and 20-2535, health care insurers shall provide at least the following INTERNAL levels of review, as applicable:

1. An expedited medical review and expedited appeal pursuant to section 20-2534.

2. An ~~informal reconsideration~~ INITIAL APPEAL pursuant to section 20-2535.

~~3. A formal appeal process pursuant to section 20-2536.~~

~~4.~~ 3. An external independent review pursuant to section 20-2537.

~~B. A health care insurer may offer additional levels of review other than the levels prescribed in subsection A of this section as long as the additional levels of review do not increase the time period limitations prescribed by this article.~~

B. FOR GROUP PLANS, A HEALTH CARE INSURER MAY ELECT TO OFFER A VOLUNTARY INTERNAL APPEAL PURSUANT TO SECTION 20-2536 AS AN ADDITIONAL INTERNAL LEVEL OF REVIEW AFTER DETERMINING AN INITIAL APPEAL.

C. FOR INDIVIDUAL PLANS, AND FOR GROUP PLANS FOR WHICH THE INSURER DOES NOT ELECT TO OFFER A VOLUNTARY INTERNAL APPEAL AS AN INTERNAL LEVEL OF REVIEW, THE INSURER SHALL:

1. FOR THE PARTIAL OR COMPLETE DENIAL OF A REQUEST FOR SERVICE, THE DENIAL, REDUCTION OR TERMINATION OF A SERVICE OR THE RESCISSION OF COVERAGE, PROVIDE THE MEMBER WITH ITS WRITTEN DETERMINATION WITHIN THIRTY DAYS AFTER THE INSURER RECEIVES THE APPEAL REQUEST.

2. FOR THE DENIAL OF A CLAIM FOR SERVICE THAT WAS ALREADY PROVIDED, PROVIDE THE MEMBER WITH ITS WRITTEN DETERMINATION WITHIN THIRTY DAYS AFTER THE INSURER RECEIVES THE APPEAL REQUEST.

D. AN INSURER THAT ELECTS TO OFFER A VOLUNTARY INTERNAL APPEAL FOR ITS GROUP PLANS SHALL:

1. FOR THE PARTIAL OR COMPLETE DENIAL OF A REQUEST FOR SERVICE, THE DENIAL, REDUCTION OR TERMINATION OF A SERVICE OR THE RESCISSION OF COVERAGE, PROVIDE THE MEMBER WITH ITS WRITTEN DETERMINATIONS WITHIN FIFTEEN DAYS AFTER THE INSURER RECEIVES THE VOLUNTARY INTERNAL APPEAL REQUEST.

2. FOR THE DENIAL OF A CLAIM FOR A SERVICE THAT WAS ALREADY PROVIDED, PROVIDE THE MEMBER WITH ITS WRITTEN DETERMINATIONS WITHIN THIRTY DAYS AFTER THE INSURER RECEIVES THE INITIAL APPEAL REQUEST AND WITHIN THIRTY DAYS AFTER THE INSURER RECEIVES THE VOLUNTARY INTERNAL APPEAL REQUEST.

E. EACH WRITTEN DETERMINATION REQUIRED BY THIS SECTION SHALL INCLUDE THE BASIS, CRITERIA USED, CLINICAL REASONS AND RATIONALE FOR THE DETERMINATION.

F. EXCEPT AS PROVIDED IN SECTIONS 20-2534 AND 20-2537, A MEMBER SHALL BE CONSIDERED TO HAVE EXHAUSTED A HEALTH CARE INSURER'S INTERNAL LEVELS OF REVIEW IF THE HEALTH CARE INSURER FAILS TO STRICTLY COMPLY WITH THE REQUIREMENTS OF THIS ARTICLE, EXCEPT TO THE EXTENT THE MEMBER REQUESTED OR AGREED TO THE DELAY, AND THE MEMBER MAY INITIATE AN EXPEDITED EXTERNAL INDEPENDENT REVIEW PURSUANT TO SECTION 20-2537, SUBSECTION L.

~~C.~~ G. At the time coverage is initiated, each health care insurer that operates in this state and whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall include a separate information packet that is approved by the director with the member's policy, evidence of coverage or similar document. At the time coverage is renewed, each health care insurer shall include a

separate statement with the member's policy, evidence of coverage or similar document that informs the member that the member can obtain a replacement packet that explains the appeal process by contacting a specific department and telephone number. A health care insurer shall also provide a copy of the information packet to the member or the member's treating provider on request ~~and to the member~~ within five business days ~~after the date the appeal is initiated pursuant to section 20-2534, 20-2535 or 20-2536~~ AND SHALL PROMINENTLY DISPLAY A COPY OF ITS APPROVED INFORMATION PACKET ON ITS WEBSITE. The information packet provided by the health care insurer shall include all of the following information:

1. A detailed description and explanation of each level of review prescribed in subsection A of this section and notice of the member's right to proceed to the next level of review if the prior review is unsuccessful.

2. An explanation of the procedures that the member must follow, including the applicable time periods, for each APPLICABLE level of review prescribed in ~~subsection~~ SUBSECTIONS A AND B of this section and an explanation of how the member may obtain the member's medical records pursuant to title 12, chapter 13, article 7.1.

3. The specific title and department of the person and the address, telephone number and ~~telefacsimile~~ FAX number of that person whom the member must notify at each APPLICABLE level of review prescribed in ~~subsection~~ SUBSECTIONS A AND B of this section in order to pursue that level of review.

4. The specific title and department of the person and the address, telephone number and ~~telefacsimile~~ FAX number of the person who will be responsible for processing that review.

5. A notice that if the member decides to pursue an appeal the member must provide the person who will be responsible for processing the appeal with any material justification or documentation for the appeal at the time that the member files the written appeal.

6. A description of the utilization review agent's and health care insurer's roles at each APPLICABLE level of review prescribed by ~~subsection~~ SUBSECTIONS A AND B of this section and an outline of the director's role during the external independent review process, if not already described in response to paragraph 1 of this subsection.

7. A notice that if the member participates in the process of review pursuant to this article the member waives any privilege of confidentiality of the member's medical records regarding any person who examined or will examine the member's medical records in connection with that review process for the medical condition under review.

8. A statement that the member is not responsible for the costs of any external independent review.

9. Standardized forms that are prescribed by the department and that a member may use to file and pursue an appeal.

10. The name and telephone number for the department of insurance consumer assistance office with a statement that the department of insurance consumer assistance office can assist consumers with questions about the health care appeals process.

~~D.~~ H. At the time of issuing a denial, the health care insurer shall notify the member of the right to appeal under this article. A health care insurer that issues an explanation of benefits document shall satisfy this obligation by prominently displaying in the document a statement about the right to appeal. A health care insurer that does not issue an explanation of benefits document shall satisfy this obligation through some other reasonable means to assure that the member is apprised of the right to appeal at the time of a denial. A reasonable means that includes giving the member's treating provider a form statement about the right to appeal shall require the treating provider to notify the member of the member's right to appeal.

~~E.~~ I. Any written notice, acknowledgment, request, ~~decision~~ DETERMINATION or other written document required to be mailed pursuant to this article is deemed received by the person to whom the document is properly addressed on the fifth business day after the request is mailed. For the purposes of this subsection, "properly addressed" means the last known address.

~~F.~~ J. The director shall require any member who files a complaint with the department relating to an adverse ~~decision~~ DETERMINATION to pursue the review process prescribed in this article. This subsection does not limit the director's authority pursuant to chapter 1, article 2 of this title.

~~G.~~ K. If the member's complaint is an issue of medical necessity under the coverage document and not whether the claim or service is covered, the ~~informal reconsideration~~ INITIAL APPEAL PROCESS shall be performed as prescribed by section 20-2535 by a licensed health care professional. If the member's complaint is an issue of medical necessity under the coverage document and not whether the claim or service is covered, the expedited review or ~~formal~~ VOLUNTARY INTERNAL appeal shall be decided by a physician, provider or other health care professional as prescribed by section 20-2534 or 20-2536. Any external independent review shall be decided by a physician, provider or other health care professional as prescribed by section 20-2537.

L. BEFORE A HEALTH CARE INSURER MAKES A FINAL ADVERSE DETERMINATION THAT RELIES ON NEW OR ADDITIONAL EVIDENCE GENERATED DIRECTLY OR INDIRECTLY BY THE HEALTH CARE INSURER, THE HEALTH CARE INSURER SHALL PROVIDE THE INFORMATION FREE OF CHARGE TO THE MEMBER SUFFICIENTLY IN ADVANCE OF THE FINAL ADVERSE DETERMINATION TO ALLOW THE MEMBER A REASONABLE OPPORTUNITY

TO RESPOND TO THE NEW INFORMATION IN ADVANCE OF THE TIME FRAME TO ISSUE A WRITTEN DETERMINATION.

~~H.~~ M. Any person given access to a member's medical records or other medical information in connection with proceedings pursuant to this article shall maintain the confidentiality of the records or information in accordance with title 12, chapter 13, article 7.1.

Sec. 5. Section 20-2534, Arizona Revised Statutes, is amended to read:

20-2534. Expedited medical review; expedited appeal

A. Any member who is denied a request for a covered service may pursue an expedited medical review of that denial if the member's treating provider certifies in writing and provides supporting documentation to the utilization review agent that the time period for the ~~informal reconsideration~~ INITIAL APPEAL process PRESCRIBED IN SECTION 20-2535 and, ~~formal~~ IF APPLICABLE, THE VOLUNTARY INTERNAL appeal process prescribed in ~~sections 20-2535 and~~ SECTION 20-2536 ~~is~~ ARE likely to cause a significant negative change in the member's medical condition at issue that is subject to the appeal. The treating provider's certification is not challengeable by the health care insurer. A health care insurer whose utilization review activities consist only of claims review for services already provided is not required to provide its members an expedited medical review or expedited appeal pursuant to this section. A health care insurer who conducts utilization review of claims in connection with services already provided is not required to provide its members an expedited medical review or expedited appeal of a claim related to a service already provided.

B. On receipt of the certification and supporting documentation, the utilization review agent has one business day to make a ~~decision~~ DETERMINATION and mail to the member and the member's treating provider a notice of that ~~decision~~ DETERMINATION, including the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION and any references to supporting documentation. If the member's complaint is an issue of medical necessity under the coverage document and not whether the service is covered, before making a ~~decision~~ DETERMINATION, the UTILIZATION REVIEW agent shall consult with a physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 17, 19 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under review.

C. If the utilization review agent affirms the denial of the requested service, the agent shall telephonically provide and mail to the member and the member's treating provider a notice of the adverse ~~decision~~ DETERMINATION and of the member's option to immediately proceed to an expedited appeal pursuant to subsection E of this section.

D. At any time during the expedited appeal process, the utilization review agent may request an expedited external independent review ~~process~~ pursuant to section 20-2537. If the utilization review agent initiates ~~the~~ AN expedited external independent review ~~process~~, the utilization review agent does not have to comply with subsection E of this section.

E. If the member chooses to proceed with an expedited appeal, the member's treating provider shall immediately submit a written appeal of the denial of the service to the utilization review agent and provide the utilization review agent with any additional material justification or documentation to support the member's request for the service. Within three business days after receiving the request for an expedited appeal, the utilization review agent shall provide notice of the expedited appeal ~~decision~~ DETERMINATION as prescribed in this subsection. If the member's complaint is an issue of medical necessity under the coverage document and not whether the service is covered, any provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who is qualified in a similar scope of practice as a provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under appeal shall review the expedited appeal and render a ~~decision~~ DETERMINATION based on the utilization review plan adopted by the utilization review agent. Pursuant to the requirements of this subsection, the utilization review agent shall select the provider, physician or other health care professional who shall review the appeal and render the ~~decision~~ DETERMINATION. If the utilization review agent, provider, physician or other health care professional denies the expedited appeal, the utilization review agent shall telephonically provide and mail to the member and the member's treating provider a notice of the denial and of the member's option to immediately proceed to the external independent review prescribed in section 20-2537.

F. If the utilization review agent, provider, physician or other health care professional concludes that the covered service should be provided, the health care insurer is bound by the utilization review agent's ~~decision~~ DETERMINATION.

Sec. 6. Section 20-2535, Arizona Revised Statutes, is amended to read:

20-2535. Initial appeal

A. Any member who is denied a service, OR WHOSE CLAIM FOR A SERVICE THAT HAS ALREADY BEEN PROVIDED IS DENIED, and who does not qualify for an

expedited medical review pursuant to section 20-2534 may request, either orally or in writing, an ~~informal reconsideration~~ INITIAL APPEAL of that denial by notifying the person described in section 20-2533, subsection ~~C~~ G, paragraph 3. After the denial, the member has up to two years to request an ~~informal reconsideration~~ INITIAL APPEAL. A health care insurer whose utilization review consists only of claims review for services already provided is not required to provide its members an ~~informal reconsideration~~ INITIAL APPEAL pursuant to this section. ~~A health care insurer who conducts utilization review of claims in connection with services already provided is not required to provide its members an informal reconsideration of a claim related to a service already provided.~~

B. The utilization review agent shall mail a written acknowledgment to the member and the member's treating provider within five business days after the utilization review agent receives the request for ~~informal reconsideration~~ AN INITIAL APPEAL.

C. The utilization review agent may request any pertinent medical records pursuant to title 12, chapter 13, article 7.1 that are necessary for the ~~informal reconsideration~~ INITIAL APPEAL.

D. IF THE MEMBER'S APPEAL IS AN ISSUE OF MEDICAL NECESSITY UNDER THE COVERAGE DOCUMENT AND NOT WHETHER THE SERVICE IS COVERED, A PROVIDER, PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR AN OUT-OF-STATE PROVIDER, PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED IN ANOTHER STATE AND WHO IS NOT LICENSED IN THIS STATE, WHO IS EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT AND WHO IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A PROVIDER, PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR AN OUT-OF-STATE PROVIDER, PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED IN ANOTHER STATE AND WHO IS NOT LICENSED IN THIS STATE AND WHO TYPICALLY MANAGES THE MEDICAL CONDITION UNDER APPEAL SHALL REVIEW THE APPEAL AND RENDER A DETERMINATION BASED ON THE UTILIZATION REVIEW PLAN ADOPTED BY THE UTILIZATION REVIEW AGENT. PURSUANT TO THE REQUIREMENTS OF THIS SUBSECTION, THE UTILIZATION REVIEW AGENT SHALL SELECT THE PROVIDER, PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO SHALL REVIEW THE APPEAL AND RENDER THE DETERMINATION.

~~D.~~ E. WITHIN THE TIME FRAMES PRESCRIBED IN SECTION 20-2533, SUBSECTIONS C AND D, the utilization review agent ~~has up to thirty days after receipt of the request for reconsideration to~~ SHALL mail to the member and the member's treating provider a notice of the utilization review agent's ~~decision~~ DETERMINATION and the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION.

~~E.~~ F. At any time during the ~~informal reconsideration~~ INITIAL APPEAL process, the utilization review agent may submit a request to the director to initiate an external independent review process pursuant to section 20-2537. At the same time that the utilization review agent

submits the request to the director, the utilization review agent shall also render a written ~~decision~~ DETERMINATION and shall send the written ~~decision~~ DETERMINATION, including the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION and any references to supporting documentation, to the member, the member's treating provider and the director.

~~F.~~ G. If the utilization review agent does not submit a request to the director pursuant to subsection ~~E~~ F of this section and at the conclusion of the ~~informal reconsideration~~ INITIAL APPEAL process the utilization review agent denies the covered service or the claim for the covered service, the utilization review agent shall provide the member and the treating provider with a written statement of the agent's decision and the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION, including any references to any supporting documentation. ~~and~~ THE DETERMINATION SHALL INCLUDE a notice of the option to proceed ~~after the formal~~ TO THE VOLUNTARY INTERNAL appeal process PURSUANT TO SECTION 20-2536 FOR A GROUP HEALTH PLAN FOR WHICH THE HEALTH CARE INSURER ELECTED TO HAVE A VOLUNTARY INTERNAL APPEAL LEVEL OF REVIEW OR to an external independent review PURSUANT TO SECTION 20-2537 IF THE MEMBER HAS ONLY ONE INTERNAL LEVEL OF REVIEW.

~~G.~~ H. If the utilization review agent concludes that the covered service should be provided or the claim for a covered service should be paid, the health care insurer is bound by the utilization review agent's ~~decision~~ DETERMINATION.

Sec. 7. Section 20-2536, Arizona Revised Statutes, is amended to read:

20-2536. Voluntary internal appeal

A. IF, FOR A GROUP HEALTH PLAN, A HEALTH CARE INSURER ELECTS TO INCLUDE AS PART OF ITS INTERNAL REVIEW LEVELS A VOLUNTARY APPEAL LEVEL after any applicable ~~informal reconsideration~~ INITIAL APPEAL pursuant to section 20-2535~~, if~~ AND the utilization review agent denies the member's ~~request for a covered service~~ INITIAL REQUEST, the member may appeal that adverse ~~decision~~ DETERMINATION TO THE VOLUNTARY APPEAL LEVEL. The member shall mail a written appeal to the utilization review agent within sixty days after receipt of the adverse ~~decision~~ DETERMINATION. ~~In the event of a denial of a claim for a service that has already been provided, the member may appeal that denial by filing a written appeal with the utilization review agent within two years after receipt of the notice of the denial.~~

B. The utilization review agent shall mail a written acknowledgment to the member and the member's treating provider within five business days after the agent receives the ~~formal~~ VOLUNTARY INTERNAL appeal.

C. The member or the member's treating provider shall submit to the utilization review agent with the written ~~formal~~ VOLUNTARY INTERNAL appeal

any material justification or documentation to support the member's request for the service or claim for a service.

D. If the member's ~~complaint~~ APPEAL is an issue of medical necessity under the coverage document and not whether the service is covered, a provider, physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who is qualified in a similar scope of practice as a provider, physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out of state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under appeal shall review the appeal and render a ~~decision~~ DETERMINATION based on the utilization review plan adopted by the utilization review agent. Pursuant to the requirements of this subsection, the utilization review agent shall select the provider, physician or other health care professional who shall review the appeal and render the ~~decision~~ DETERMINATION.

E. Except as provided in subsection F of this section, the utilization review agent ~~has:~~

~~1. With respect to adverse decisions relating to services that have not been provided, up to thirty days after receipt of the written appeal to notify the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.~~

~~2. With respect to denials relating to claims that have already been provided, up to sixty days after receipt of the written appeal to notify the member in writing of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.~~ SHALL MAIL TO THE MEMBER AND THE MEMBER'S TREATING PROVIDER A NOTICE OF THE UTILIZATION REVIEW AGENT'S DETERMINATION AND THE BASIS, CRITERIA USED, CLINICAL REASONS AND RATIONALE FOR THAT DETERMINATION WITHIN THE TIME FRAMES PRESCRIBED IN SECTION 20-2533, SUBSECTION D.

F. At any time during the ~~formal~~ VOLUNTARY INTERNAL appeal process, the utilization review agent may request an external independent review process pursuant to section 20-2537. If the utilization review agent initiates the external independent review process, the utilization review agent does not have to comply with subsection E of this section.

G. If at the conclusion of the ~~formal~~ VOLUNTARY INTERNAL appeal process the utilization review agent denies the appeal and the utilization review agent does not initiate the external independent review process, the utilization review agent shall provide the member with notice of the option to proceed to an external independent review pursuant to section 20-2537.

H. If the utilization review agent concludes that the covered service should be provided or the claim for a covered service should be paid, the health care insurer is bound by the utilization review agent's ~~decision~~ DETERMINATION.

Sec. 8. Section 20-2537, Arizona Revised Statutes, is amended to read:

20-2537. External independent review; expedited external independent review

A. If the utilization review agent denies the member's request for a covered service or claim for a covered service at ~~both the informal reconsideration level and the formal appeal level, or at the expedited medical review level~~ ALL APPLICABLE INTERNAL LEVELS OF REVIEW OR IF THE MEMBER HAS EXHAUSTED THE HEALTH CARE INSURER'S INTERNAL LEVELS OF REVIEW PURSUANT TO SECTION 20-2533, SUBSECTION F, the member may initiate an external independent review.

B. Except as provided in subsection ~~K~~ L of this section, A MEMBER MAY INITIATE AN EXTERNAL INDEPENDENT REVIEW within four months after the member receives written notice by the utilization review agent of ~~the~~ AN adverse ~~decision~~ DETERMINATION made pursuant to section 20-2534 or 20-2536~~, if the member decides to initiate an external independent review, the member shall mail~~ BY MAILING to the utilization review agent a written request for an external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service.

C. Except as provided in subsection ~~K~~ L of this section, within five business days after the utilization review agent receives a request for an external independent review from the member pursuant to subsection B of this section or the director pursuant to subsection ~~G~~ H of this section, or if the utilization review agent initiates an external independent review pursuant to section 20-2536, subsection F, the utilization review agent shall:

1. Mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer. THE ACKNOWLEDGEMENT SHALL INCLUDE NOTICE TO THE MEMBER THAT THE MEMBER HAS FIVE BUSINESS DAYS AFTER RECEIPT OF THE NOTICE TO SUBMIT ADDITIONAL WRITTEN EVIDENCE TO THE DEPARTMENT FOR CONSIDERATION BY THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION.

2. Forward to the director the request for review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the ~~decision~~ DETERMINATION pertaining to the member's case, a summary description of the applicable issues, including a statement of the utilization review agent's ~~decision~~ DETERMINATION, the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION, the relevant portions of the utilization review agent's

utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2533, subsection ~~G~~ K.

D. Except as provided in subsection ~~K~~ L of this section, within five days after the director receives all of the information prescribed in subsection C, paragraph 2 of this section and if the case involves an issue of medical necessity under the coverage document, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by subsection C, paragraph 2 of this section.

E. WITHIN ONE BUSINESS DAY AFTER THE DIRECTOR RECEIVES ADDITIONAL WRITTEN EVIDENCE SUBMITTED BY THE MEMBER PURSUANT TO SUBSECTION C, PARAGRAPH 1 OF THIS SECTION, THE DIRECTOR SHALL PROVIDE A COPY OF THE EVIDENCE TO THE HEALTH CARE INSURER AND THE INDEPENDENT REVIEW ORGANIZATION. THE INDEPENDENT REVIEW ORGANIZATION SHALL CONSIDER THE EVIDENCE IN MAKING ITS DETERMINATION. THE INDEPENDENT REVIEW ORGANIZATION, IN ITS SOLE DISCRETION, MAY CONSIDER EVIDENCE SUBMITTED AFTER FIVE BUSINESS DAYS.

~~E.~~ F. Except as provided in subsection ~~K~~ L of this section, for cases involving an issue of medical necessity under the coverage document, within twenty-one days after the date of receiving a case for independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a ~~decision~~ DETERMINATION that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary and send the ~~decision~~ DETERMINATION to the director. Within five business days after receiving a notice of ~~decision~~ DETERMINATION from the independent review organization, the director shall mail a notice of the ~~decision~~ DETERMINATION to the utilization review agent, the health care insurer, the member and the member's treating provider. The ~~decision~~ DETERMINATION by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.

~~F.~~ G. Except as provided in subsection ~~K~~ L of this section, for cases involving an issue of coverage, within fifteen business days after receipt of all of the information prescribed in subsection C, paragraph 2 of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse ~~decision~~ DETERMINATION made pursuant to section 20-2536 conforms to the utilization review agent's utilization review plan and this article and

shall mail a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

~~G.~~ H. If the director finds that the case involves a medical issue or is unable to determine issues of coverage, the director shall submit the member's case to the external independent review organization in accordance with subsections ~~E~~ F and ~~K~~ L of this section.

~~H.~~ I. After a ~~decision~~ DETERMINATION is made pursuant to subsection ~~E, F, G or K~~ F, G, H OR L of this section, the reconsideration, appeal and administrative processes are completed and the department's role is ended, except:

1. To transmit, when necessary, a record of the proceedings to superior court or to the office of administrative hearings.

2. To issue a final administrative decision pursuant to section 41-1092.08.

~~I.~~ J. Except as provided in subsection ~~K~~ L of this section, on written request by the independent review organization, the member or the utilization review agent, the director may extend the twenty-one day time period prescribed in subsection ~~E~~ F of this section for up to an additional thirty days if the requesting party demonstrates good cause for an extension.

~~J.~~ K. A ~~decision~~ DETERMINATION made by the director or an independent review organization pursuant to this section is admissible in proceedings involving a health care insurer or utilization review agent.

~~K.~~ L. If the utilization review agent denies the member's request for a covered service or claim for a covered service at the expedited medical review level presented and resolved pursuant to section 20-2534, subsections A and E, DENIES A HEALTH CARE SERVICE FOR WHICH THE MEMBER RECEIVED EMERGENCY SERVICES BUT HAS NOT YET BEEN DISCHARGED OR DENIES, REDUCES OR TERMINATES COVERAGE FOR A MEMBER'S ADMISSION, THE AVAILABILITY OF CARE, A CONTINUED STAY OR A COURSE OF TREATMENT BEFORE THE END OF THE PERIOD OF TIME OR NUMBER OF TREATMENTS RECOMMENDED BY THE TREATING PROVIDER, OR A MEMBER EXHAUSTED THE HEALTH CARE INSURER'S INTERNAL LEVELS OF REVIEW PURSUANT TO SECTION 20-2533, SUBSECTION F, the member may initiate an expedited external independent review in accordance with the following:

1. Within five business days after the member receives written notice by the utilization review agent of the adverse ~~decision~~ DETERMINATION made pursuant to section 20-2534, if the member decides to initiate an external independent review, the member shall mail to the utilization review agent a written request for an expedited external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service.

2. Within one business day after the utilization review agent receives a request for an expedited external independent review from the

member pursuant to this subsection or if the utilization review agent initiates an expedited external independent review pursuant to section 20-2534, subsection D, the utilization review agent shall:

(a) Mail a written acknowledgment to the director, the member, the member's treating provider and the health care insurer.

(b) Forward to the director the request for an expedited independent external review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the ~~decision~~ DETERMINATION pertaining to the member's case, a summary description of the applicable issues, including a statement of the utilization review agent's ~~decision~~ DETERMINATION, the BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~ DETERMINATION, the relevant portions of the utilization review agent's utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2534, subsection B.

3. Within two business days after the director receives all of the information prescribed in this subsection and if the case involves an issue of medical necessity, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by this subsection.

4. For cases involving an issue of medical necessity, within seventy-two hours from the date of receiving a case for expedited external independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a ~~decision~~ DETERMINATION that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary and send the ~~decision~~ DETERMINATION to the director. Within one business day after receiving a notice of ~~decision~~ DETERMINATION from the independent review organization, the director shall mail a notice of the ~~decision~~ DETERMINATION to the utilization review agent, the health care insurer, the member and the member's treating provider. The ~~decision~~ DETERMINATION by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.

5. For cases involving an issue of coverage, within two business days after receipt of all of the information prescribed in subsection C of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse ~~decision~~ DETERMINATION made pursuant to section 20-2534 conforms to the

utilization review agent's utilization review plan and this article and shall mail a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

~~L.~~ M. Notwithstanding title 41, chapter 6, article 10 and section 12-908, if a party to a decision issued under this section seeks further administrative review, the department shall not be a party to the action unless the department files a motion to intervene in the action.

~~M.~~ N. The independent review organization, the director or the office of administrative hearings may not order the health care insurer to provide a service or to pay a claim for a benefit or service that is excluded from coverage by the contract.

~~N.~~ O. The health care insurer shall provide any service or pay any claim determined in a final administrative decision to be covered and medically necessary for the case under review regardless of whether judicial review is sought. Any proceedings before the office of administrative hearings that involve an expedited external independent review and that are subject to subsection ~~K~~ L of this section shall be promptly instituted and completed.

Sec. 9. Section 20-2541, Arizona Revised Statutes, is amended to read:

20-2541. Health care insurer fee

The director of the department of insurance may assess each health care insurer that is authorized to transact insurance:

1. A single fee of not more than two hundred dollars per insurer.

2. Up to two hundred dollars each year ~~for the costs of performing~~ TO COMPENSATE EMPLOYEES AND PAY EXPENSES TO PERFORM the responsibilities relating to the procurement of independent review organizations as prescribed in sections 20-2537 and 20-2538 and ~~for implementing and maintaining~~ TO IMPLEMENT AND MAINTAIN the external independent review process, including processing and paying claims through the health care appeals fund established by section 20-2540. ~~The department of insurance is authorized one full-time equivalent position to perform these responsibilities.~~

Sec. 10. Title 20, chapter 15, article 2, Arizona Revised Statutes, is amended by adding sections 20-2542 and 20-2543, to read:

20-2542. Drugs not covered by health plan; exception requests; appeal; definitions

A. EACH HEALTH CARE INSURER SHALL ESTABLISH STANDARD AND EXPEDITED EXCEPTION REQUEST PROCESSES BY WHICH A MEMBER MAY REQUEST THAT THE HEALTH CARE INSURER COVER A CLINICALLY APPROPRIATE DRUG THAT WOULD OTHERWISE NOT BE COVERED BY THE HEALTH PLAN. THE EXCEPTION REQUEST PROCESSES SHALL PERMIT A MEMBER TO REQUEST AN EXTERNAL INDEPENDENT REVIEW OF THE HEALTH CARE INSURER'S INITIAL DETERMINATION ON THE EXCEPTION REQUEST.

B. EACH HEALTH CARE INSURER SHALL PROVIDE ITS MEMBERS A DETAILED WRITTEN DESCRIPTION OF ITS EXCEPTION REQUEST PROCESSES THAT SHALL INCLUDE

THE E-MAIL ADDRESS, FAX NUMBER AND PHYSICAL ADDRESS WHERE A MEMBER CAN E-MAIL, TRANSMIT OR DELIVER AN EXCEPTION REQUEST. THE HEALTH CARE INSURER SHALL ALSO PROMINENTLY DISPLAY THE PROCESSES ON ITS WEBSITE AND MAY ALSO ELECT TO INCLUDE THIS INFORMATION IN ITS HEALTH CARE APPEAL INFORMATION PACKET.

C. THE HEALTH CARE INSURER SHALL MAKE A DETERMINATION AND NOTIFY THE MEMBER AND THE MEMBER'S PRESCRIBING PHYSICIAN OF THAT DETERMINATION AND OF THE STEPS TO REQUEST AN EXTERNAL REVIEW OF THAT DETERMINATION EITHER:

1. WITHIN SEVENTY-TWO HOURS AFTER THE INSURER'S RECEIPT OF A STANDARD EXCEPTION REQUEST.

2. WITHIN TWENTY-FOUR HOURS AFTER THE INSURER'S RECEIPT OF AN EXPEDITED EXCEPTION REQUEST.

D. IF THE INSURER DENIES THE EXCEPTION REQUEST, THE MEMBER OR PRESCRIBING PROVIDER MAY REQUEST AN EXTERNAL REVIEW OF THE EXCEPTION REQUEST. ON RECEIVING A REQUEST FOR EXTERNAL REVIEW, THE HEALTH CARE INSURER SHALL FORWARD THE REQUEST TO AN INDEPENDENT REVIEW ORGANIZATION THAT MEETS THE REQUIREMENTS OF SECTION 20-2538, SUBSECTIONS B, C AND D AND WHO USES PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS, ALL OF WHOM MEET THE REQUIREMENTS OF SECTION 20-2538, SUBSECTIONS B, C AND D.

E. THE INDEPENDENT REVIEW ORGANIZATION SHALL MAKE A DETERMINATION AND NOTIFY THE MEMBER, THE MEMBER'S PHYSICIAN, THE HEALTH CARE INSURER AND THE DEPARTMENT OF ITS DETERMINATION ON THE EXTERNAL REVIEW EXCEPTION REQUEST EITHER:

1. WITHIN SEVENTY-TWO HOURS AFTER THE INSURER'S RECEIPT OF THE REQUEST FOR STANDARD EXTERNAL REVIEW.

2. WITHIN TWENTY-FOUR HOURS AFTER THE INSURER'S RECEIPT OF THE REQUEST FOR EXPEDITED EXTERNAL REVIEW.

F. IF A STANDARD EXCEPTION REQUEST IS APPROVED, THE HEALTH CARE INSURER SHALL PROVIDE COVERAGE FOR THE NONFORMULARY DRUG FOR THE DURATION OF THE PRESCRIPTION, INCLUDING REFILLS.

G. IF AN EXPEDITED EXCEPTION REQUEST IS APPROVED, THE HEALTH CARE INSURER SHALL PROVIDE COVERAGE FOR THE NONFORMULARY DRUG FOR THE DURATION OF THE EXIGENT CIRCUMSTANCES.

H. A MEMBER WHO PURSUES A FORMULARY EXCEPTION REQUEST UNDER THIS SECTION MAY NOT PURSUE ANY HEALTH CARE APPEAL UNDER SECTIONS 20-2533, 20-2534, 20-2535, 20-2536 OR 20-2537 FOR THE FORMULARY EXCEPTION.

I. THIS SECTION DOES NOT APPLY TO LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

J. FOR THE PURPOSES OF THIS SECTION:

1. "EXIGENT CIRCUMSTANCE" MEANS THE MEMBER IS SUFFERING FROM A HEALTH CONDITION THAT MAY SERIOUSLY JEOPARDIZE THE MEMBER'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION.

2. "EXPEDITED EXCEPTION REQUEST" MEANS A REQUEST FOR APPROVAL OF A CLINICALLY APPROPRIATE DRUG THAT IS NOT OTHERWISE A COVERED BENEFIT IN AN

EXIGENT CIRCUMSTANCE OR WHEN THE MEMBER IS UNDERGOING A CURRENT COURSE OF TREATMENT USING A NONFORMULARY DRUG.

3. "INSURER'S RECEIPT" MEANS THE DAY AND TIME THAT A REQUEST IS E-MAILED, TRANSMITTED BY FAX OR DELIVERED TO THE LOCATIONS DESIGNATED IN THE INSURER'S WRITTEN FORMULARY EXCEPTION PROCESSES PROVIDED TO THE MEMBER.

4. "STANDARD EXCEPTION REQUEST" MEANS A REQUEST FOR APPROVAL OF A CLINICALLY APPROPRIATE DRUG THAT IS NOT OTHERWISE A COVERED BENEFIT IF THERE ARE NO EXIGENT CIRCUMSTANCES.

20-2543. Recordkeeping

A HEALTH CARE INSURER SHALL MAINTAIN ALL RECORDS THAT DOCUMENT INTERNAL AND EXTERNAL APPEALS AND EXCEPTION REQUESTS FOR AT LEAST SIX YEARS AFTER THE COMPLETION OF THE APPEALS PROCESS OR EXCEPTION REQUEST PROCESS.

Sec. 11. Effective date

This act is effective from and after December 31, 2017.