

State of Arizona  
House of Representatives  
Fifty-sixth Legislature  
Second Regular Session  
2024

**CHAPTER 178**  
**HOUSE BILL 2599**

AN ACT

AMENDING SECTIONS 20-2501, 20-2532, 20-2533, 20-2534, 20-2535, 20-2536 AND 20-2537, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 15, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2542; RELATING TO UTILIZATION REVIEWS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:  
2 Section 1. Section 20-2501, Arizona Revised Statutes, is amended to  
3 read:  
4 20-2501. Definitions; scope  
5 A. In this chapter, unless the context otherwise requires:  
6 1. "Adverse ~~decision~~ DETERMINATION":  
7 (a) Means a utilization review determination by the utilization  
8 review agent that a requested service or claim for service OR A DENIAL,  
9 REDUCTION OR TERMINATION OF A SERVICE, IN WHOLE OR IN PART, is not a  
10 covered service, or is not medically necessary OR APPROPRIATE, INCLUDING  
11 HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT,  
12 OR IS EXPERIMENTAL OR INVESTIGATIONAL under the plan if that determination  
13 results in a documented denial or nonpayment of the service or claim.  
14 (b) INCLUDES A RESCISSION.  
15 2. "Benefits based on the health status of the insured" means a  
16 contract of insurance to pay a fixed benefit amount, without regard to the  
17 specific services received, to a policyholder who meets certain  
18 eligibility criteria based on health status including:  
19 (a) A disability income insurance policy that pays a fixed daily,  
20 weekly or monthly benefit amount to an insured who is deemed to have a  
21 disability as defined by the policy terms.  
22 (b) A hospital indemnity policy that pays a fixed daily benefit  
23 during hospital confinement.  
24 (c) A disability insurance policy that pays a fixed daily, weekly  
25 or monthly benefit amount to an insured who is certified by a licensed  
26 health care professional as chronically ill as defined by the policy  
27 terms.  
28 (d) A disability insurance policy that pays a fixed daily, weekly  
29 or monthly benefit amount to an insured who suffers from a prolonged  
30 physical illness, disability or cognitive disorder as defined by the  
31 policy terms.  
32 3. "Claim":  
33 (a) Means a request for payment for a service already provided.  
34 ~~Claim~~  
35 (b) Does not include:  
36 ~~(a)~~ (i) Claim adjustments for usual and customary charges for a  
37 service or coordination of benefits between health care insurers.  
38 ~~(b)~~ (ii) A request for payment under a policy or contract that  
39 pays benefits based on the health status of the insured and that does not  
40 reimburse the cost of or provide covered services.  
41 4. "Covered service" means a service that is included in a policy,  
42 evidence of coverage or similar document that specifies which services,  
43 insurance or other benefits are included or covered.

1           5. "Denial":

2           (a) Means a direct or indirect determination regarding all or part  
3 of a request for any service.

4           (b) INCLUDES A DENIAL, REDUCTION OR TERMINATION OF A SERVICE OR A  
5 RESCISSION or a direct determination regarding a claim that may trigger a  
6 request for review. ~~or reconsideration. Denial~~

7           (c) Does not include:

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

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

15           6. "FINAL INTERNAL ADVERSE DETERMINATION" MEANS AN ADVERSE  
16 DETERMINATION THAT IS UPHELD, IN WHOLE OR IN PART, AT THE COMPLETION OF  
17 THE HEALTH CARE INSURER'S INTERNAL LEVELS OF REVIEW OR AN ADVERSE  
18 DETERMINATION WITH RESPECT TO WHICH THE INTERNAL LEVELS OF REVIEW HAVE  
19 BEEN WAIVED OR DEEMED EXHAUSTED.

20           7. "GRANDFATHERED INDIVIDUAL PLAN" MEANS COVERAGE PROVIDED BY AN  
21 INDIVIDUAL HEALTH CARE INSURER WHICH WAS PURCHASED BEFORE MARCH 23, 2010  
22 AND WHICH HAS NOT LOST SUCH STATUS DUE TO CHANGES IN BENEFITS.

23           ~~6.~~ 8. "Health care insurer" means a disability insurer, group  
24 disability insurer, blanket disability insurer, health care services  
25 organization, hospital service corporation, prepaid dental plan  
26 organization, medical service corporation, dental service corporation or  
27 optometric service corporation or a hospital, medical, dental and  
28 optometric service corporation.

29           9. "HEALTH CARE SETTING" MEANS AN INSTITUTION PROVIDING HEALTH CARE  
30 SERVICES, INCLUDING BUT NOT LIMITED TO, HOSPITALS AND OTHER LICENSED  
31 INPATIENT CENTERS, AMBULATORY SURGICAL OR TREATMENT CENTERS, SKILLED  
32 NURSING CENTERS, RESIDENTIAL TREATMENT CENTERS, DIAGNOSTIC, LABORATORY AND  
33 IMAGING CENTERS AND REHABILITATION AND OTHER THERAPEUTIC HEALTH SETTINGS.

34           ~~7.~~ 10. "Indirect denial" means a failure to communicate  
35 authorization or nonauthorization to the member by the utilization review  
36 agent within ~~ten business days~~ THE PRESCRIBED TIME FRAMES PURSUANT TO  
37 SECTION 20-3404 after the utilization review agent receives the request  
38 for a covered service.

39           11. "INTERNAL LEVELS OF REVIEW" MEANS:

40           (a) AN EXPEDITED MEDICAL REVIEW AND EXPEDITED APPEAL PURSUANT TO  
41 SECTION 20-2534.

42           (b) AN INITIAL INTERNAL APPEAL PURSUANT TO SECTION 20-2535.

43           (c) A VOLUNTARY INTERNAL APPEAL PURSUANT TO SECTION 20-2536, IF  
44 APPLICABLE.

1       ~~8.~~ 12. "Provider" means the physician or other licensed  
2 practitioner identified to the utilization review agent as having primary  
3 responsibility for providing care, treatment and services rendered to a  
4 patient.

5       13. "RESCISSION" MEANS A RETROACTIVE CANCELLATION OF COVERAGE THAT  
6 IS NOT RELATED TO A FAILURE TO TIMELY PAY REQUIRED PREMIUMS.

7       ~~9.~~ 14. "Service" means a diagnostic or therapeutic medical or  
8 health care service, benefit or treatment.

9       ~~10.~~ 15. "Utilization review" means a system for reviewing the  
10 appropriate and efficient allocation of inpatient hospital resources,  
11 inpatient medical services and outpatient surgery services that are being  
12 given or are proposed to be given to a patient, and of any medical,  
13 surgical and health care services or claims for services that may be  
14 covered by a health care insurer depending on determinable contingencies,  
15 including without limitation outpatient services, in-office consultations  
16 with medical specialists, specialized diagnostic testing, mental health  
17 services, emergency care and inpatient and outpatient hospital services.  
18 Utilization review does not include elective requests for the  
19 clarification of coverage.

20       ~~11.~~ 16. "Utilization review agent" means a person or entity that  
21 performs utilization review. For purposes of article 2 of this chapter,  
22 utilization review agent has the same meaning prescribed in section  
23 20-2530. For purposes of this chapter, utilization review agent does not  
24 include:

- 25           (a) A governmental agency.
- 26           (b) An agent that acts on behalf of the governmental agency.
- 27           (c) An employee of a utilization review agent.

28       ~~12.~~ 17. "Utilization review plan" means a summary description of  
29 the utilization review guidelines, protocols, procedures and written  
30 standards and criteria of a utilization review agent.

31           B. For the purposes of this chapter, utilization review by an  
32 optometric service corporation applies only to nonsurgical medical and  
33 health care services.

34           Sec. 2. Section 20-2532, Arizona Revised Statutes, is amended to  
35 read:

36           20-2532. Utilization review standards and criteria;  
37 requirements

38           A. Each utilization review agent shall:

39           1. Adopt a written utilization review plan with standards and  
40 criteria that apply to all utilization review ~~decisions~~ DETERMINATIONS and  
41 that are objective, clinically valid and compatible with established  
42 principles of health care.

43           2. Establish the utilization review plan with input from physician  
44 advisors who represent major medical specialties and who are certified or

1 board eligible under the standards of the appropriate American medical  
2 specialty board.

3 3. Include in the adopted utilization review plan a process for  
4 prompt initial reconsideration of an adverse ~~decision~~ DETERMINATION and a  
5 process for appeals that meet the requirements of this article. This  
6 paragraph does not apply to utilization review activities limited to  
7 retrospective claims review.

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

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

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

30 E. Each utilization review agent shall file a notice with the  
31 director that provides a specific description and the published date of  
32 the source of the written standards and criteria of the utilization review  
33 plan and that certifies that the utilization review plan in use complies  
34 with the requirements of this section, is available for review and  
35 inspection at a designated location in this state or at an office  
36 accessible to authorized representatives of the director in another state  
37 and is the complete utilization review plan with all standards and  
38 criteria on which utilization review decisions are based. A copy of any  
39 portion of the utilization review plan on which any adverse ~~decisions~~  
40 DETERMINATIONS have been based shall be made before the effective date of  
41 any modification and the utilization review agent shall retain a copy at  
42 the designated location for review and inspection for a period of five  
43 years after the date of the modification. If at any time a complete

1 change in the written standards and criteria occurs, the utilization  
2 review agent shall file a new certification notice with the director.

3 F. On or before March 1 of each year after the year in which the  
4 utilization review agent filed the notice prescribed in subsection E of  
5 this section, the utilization review agent or the agent's successor shall  
6 submit a signed and notarized annual report to the director that includes  
7 the designated location for review and inspection by the director or the  
8 director's authorized representative and that certifies that:

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

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

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

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

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

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

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

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

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

37 Sec. 3. Section 20-2533, Arizona Revised Statutes, is amended to  
38 read:

39 20-2533. Denial; levels of review; disclosure; additional  
40 time after service by mail; review process

41 A. NO MINIMUM DOLLAR AMOUNT MAY BE IMPOSED ON ANY CLAIM THAT IS THE  
42 SUBJECT OF AN ADVERSE DETERMINATION FOR A MEMBER TO, AND any member who  
43 ~~is denied a covered service or whose claim for a service is denied~~  
44 RECEIVES AN ADVERSE DETERMINATION may, pursue the applicable review

1 process prescribed in this article. Except as provided in sections  
2 20-2534 and 20-2535, health care insurers shall provide at least the  
3 following levels of review, as applicable:

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

6 2. An ~~informal reconsideration~~ INITIAL APPEAL pursuant to section  
7 20-2535.

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

9 ~~4.~~ 3. An external independent review pursuant to section 20-2537.

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

14 B. FOR GROUP PLANS, AND FOR GRANDFATHERED INDIVIDUAL PLANS, A  
15 HEALTH CARE INSURER MAY ELECT TO OFFER A VOLUNTARY INTERNAL APPEAL  
16 PURSUANT TO SECTION 20-2536 AS AN ADDITIONAL INTERNAL LEVEL OF REVIEW  
17 AFTER A DETERMINATION OF AN INITIAL APPEAL.

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

21 1. WITH THE EXCEPTION OF A DENIAL OF A CLAIM FOR SERVICE THAT HAS  
22 ALREADY BEEN PROVIDED, SEND THE MEMBER A WRITTEN DETERMINATION WITHIN  
23 THIRTY DAYS AFTER THE HEALTH CARE INSURER RECEIVES THE APPEAL REQUEST.

24 2. FOR A DENIAL OF A CLAIM FOR SERVICE THAT HAS ALREADY BEEN  
25 PROVIDED, SEND THE MEMBER A WRITTEN DETERMINATION WITHIN SIXTY DAYS AFTER  
26 THE HEALTH CARE INSURER RECEIVES THE APPEAL REQUEST.

27 D. A HEALTH CARE INSURER THAT ELECTS TO OFFER A VOLUNTARY INTERNAL  
28 APPEAL FOR THE HEALTH CARE INSURER'S GROUP PLANS SHALL:

29 1. WITH THE EXCEPTION OF A DENIAL OF A CLAIM FOR SERVICE THAT HAS  
30 ALREADY BEEN PROVIDED, SEND THE MEMBER A WRITTEN DETERMINATION WITHIN  
31 FIFTEEN DAYS AFTER THE HEALTH CARE INSURER RECEIVES THE INITIAL APPEAL  
32 REQUEST AND WITHIN FIFTEEN DAYS AFTER THE HEALTH CARE INSURER RECEIVES THE  
33 VOLUNTARY INTERNAL APPEAL REQUEST.

34 2. FOR A DENIAL OF A CLAIM FOR A SERVICE THAT HAS ALREADY BEEN  
35 PROVIDED, SEND THE MEMBER ITS WRITTEN DETERMINATION WITHIN THIRTY DAYS  
36 AFTER THE HEALTH CARE INSURER RECEIVES THE HEALTH CARE INSURER RECEIVES  
37 THE INITIAL APPEAL REQUEST AND WITHIN THIRTY DAYS AFTER THE HEALTH CARE  
38 INSURER RECEIVES THE VOLUNTARY INTERNAL APPEAL REQUEST.

39 E. A HEALTH CARE INSURER SHALL PROVIDE A WRITTEN DETERMINATION AS  
40 REQUIRED BY THIS SECTION AND INCLUDE THE BASIS, CRITERIA USED, CLINICAL  
41 REASONS AND RATIONALE FOR THE DETERMINATION.

42 F. EXCEPT AS PROVIDED IN SECTIONS 20-2534 AND 20-2537, A MEMBER  
43 SHALL BE CONSIDERED TO HAVE EXHAUSTED A HEALTH CARE INSURER'S INTERNAL  
44 LEVELS OF REVIEW IF THE HEALTH CARE INSURER FAILS TO COMPLY WITH THIS

1 ARTICLE, EXCEPT TO THE EXTENT THAT THE MEMBER REQUESTED OR AGREED TO THE  
2 DELAY, AND THE MEMBER MAY SIMULTANEOUSLY INITIATE AN EXPEDITED EXTERNAL  
3 INDEPENDENT REVIEW.

4 G. NOTWITHSTANDING SUBSECTION A, PARAGRAPH 2 OF THIS SECTION, A  
5 HEALTH CARE INSURER MAY WAIVE THE INTERNAL APPEAL PROCESS.

6 ~~E.~~ H. At the time coverage is initiated, each health care insurer  
7 that operates in this state and whose utilization review system includes  
8 the power to affect the direct or indirect denial of requested medical or  
9 health care services or claims for medical or health care services shall  
10 include a separate information packet that is approved by the director  
11 with the member's policy, evidence of coverage or similar document. At  
12 the time coverage is renewed, each health care insurer shall include a  
13 separate statement with the member's policy, evidence of coverage or  
14 similar document that informs the member that the member can obtain a  
15 replacement packet that explains the appeal process by contacting a  
16 specific department and telephone number. A health care insurer shall  
17 also provide a copy of the information packet to the member or the  
18 member's treating provider on request and ~~provide access to a copy of the~~  
19 ~~SHALL PROMINENTLY DISPLAY A COPY OF THE APPROVED~~ information packet on its  
20 website. The information packet provided by the health care insurer shall  
21 include all of the following information:

22 1. A detailed description and explanation of each level of review  
23 prescribed in ~~subsection~~ SUBSECTIONS A AND B of this section and notice of  
24 the member's right to proceed to the next level of review if the prior  
25 review is unsuccessful.

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

31 3. The specific title and department of the person and the address,  
32 telephone number and fax number or email address of the person whom the  
33 member must notify at each APPLICABLE level of review prescribed in  
34 ~~subsection~~ SUBSECTIONS A AND B of this section in order to pursue that  
35 level of review.

36 4. The specific title and department of the person and the address,  
37 telephone number and fax number or email address of the person who will be  
38 responsible for processing that review.

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



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

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

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

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

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

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

31           ~~E.~~ J. Any written notice, acknowledgment, request, ~~decision~~  
32 DETERMINATION or other written document that is sent by mail is deemed  
33 received by the person to whom the document is properly addressed on the  
34 fifth business day after mailing.

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

40           ~~G.~~ L. If the member's complaint ~~is~~ INVOLVES an issue of medical  
41 necessity OR APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL OF CARE  
42 OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR  
43 INVESTIGATIONAL under the coverage document and not whether the claim or  
44 service is covered, the ~~informal reconsideration~~ INITIAL APPEAL PROCESS

1 shall be performed as prescribed by section 20-2535 by a licensed health  
2 care professional. If the member's complaint ~~is~~ INVOLVES an issue of  
3 medical necessity OR APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL  
4 OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR  
5 INVESTIGATIONAL under the coverage document and not whether the claim or  
6 service is covered, the expedited review or ~~format~~ VOLUNTARY INTERNAL  
7 appeal shall be decided by a physician, provider or other health care  
8 professional as prescribed by section 20-2534 or 20-2536. Any external  
9 independent review shall be decided by a physician, provider or other  
10 health care professional as prescribed by section 20-2537.

11 M. BEFORE A HEALTH CARE INSURER MAKES A FINAL INTERNAL ADVERSE  
12 DETERMINATION THAT RELIES ON NEW OR ADDITIONAL EVIDENCE GENERATED DIRECTLY  
13 OR INDIRECTLY BY THE HEALTH CARE INSURER, THE HEALTH CARE INSURER SHALL  
14 PROVIDE THE NEW OR ADDITIONAL INFORMATION TO THE MEMBER FREE OF CHARGE  
15 SUFFICIENTLY IN ADVANCE OF THE FINAL ADVERSE DETERMINATION TO ALLOW THE  
16 MEMBER A REASONABLE OPPORTUNITY TO RESPOND WITHIN THE APPLICABLE TIME  
17 FRAMES FOR THE HEALTH CARE INSURER TO PROVIDE THE MEMBER WITH A WRITTEN  
18 DETERMINATION PRESCRIBED IN SUBSECTIONS C AND D OF THIS SECTION.

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

23 Sec. 4. Section 20-2534, Arizona Revised Statutes, is amended to  
24 read:

25 20-2534. Expedited medical review; expedited appeal

26 A. EXCEPT FOR A DENIAL OF A CLAIM FOR SERVICE OR A RESCISSION OF  
27 COVERAGE, any member who ~~is denied a request for a covered service~~  
28 RECEIVES AN ADVERSE DETERMINATION may pursue an expedited medical review  
29 of that denial if the member's treating provider certifies in writing and  
30 provides supporting documentation to the utilization review agent that the  
31 time period for the ~~informal reconsideration~~ INITIAL APPEAL process ~~and~~  
32 ~~format~~ PRESCRIBED IN SECTION 20-2535 AND, IF APPLICABLE, THE VOLUNTARY  
33 INTERNAL appeal process prescribed in ~~sections 20-2535 and~~ SECTION 20-2536  
34 ~~is~~ ARE likely to cause a significant negative change in the member's  
35 medical condition at issue that is subject to the appeal. The treating  
36 provider's certification is not challengeable by the health care  
37 insurer. A health care insurer whose utilization review activities  
38 consist only of claims review for services already provided is not  
39 required to provide its members an expedited medical review or expedited  
40 appeal pursuant to this section. A health care insurer who conducts  
41 utilization review of claims in connection with services already provided  
42 is not required to provide its members an expedited medical review or  
43 expedited appeal of a claim related to a service already provided.

1           B. On receipt of the certification and supporting documentation,  
2 the utilization review agent has ~~one business day~~ SEVENTY-TWO HOURS to  
3 make a ~~decision~~ DETERMINATION and send to the member and the member's  
4 treating provider a notice of that ~~decision~~ DETERMINATION, including the  
5 BASIS, criteria used, ~~and the~~ clinical reasons AND RATIONALE for that  
6 ~~decision~~ DETERMINATION and any references to supporting documentation. If  
7 the member's complaint ~~is~~ INVOLVES an issue of medical necessity OR  
8 APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR  
9 EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL  
10 under the coverage document and not whether the service is covered, before  
11 making a ~~decision~~ DETERMINATION, the agent shall consult with a physician  
12 or other health care professional who is licensed pursuant to title 32,  
13 chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out-of-state  
14 provider, physician or other health care professional who is licensed in  
15 another state and who is not licensed in this state and who typically  
16 manages the medical condition under review.

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

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

27           E. If the member chooses to proceed with an expedited appeal, the  
28 member's treating provider shall immediately submit a written appeal of  
29 the denial of the service to the utilization review agent and provide the  
30 utilization review agent with any additional material justification or  
31 documentation to support the member's request for the service. Within  
32 three business days after receiving the request for an expedited appeal,  
33 the utilization review agent shall provide notice of the expedited appeal  
34 ~~decision~~ DETERMINATION as prescribed in this subsection. If the member's  
35 complaint ~~is~~ INVOLVES an issue of medical necessity OR APPROPRIATENESS,  
36 INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A COVERED  
37 BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL under the coverage document  
38 and not whether the service is covered, ~~any provider, physician or other~~  
39 ~~health care professional who is licensed pursuant to title 32, chapter 7,~~  
40 ~~8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out-of-state provider,~~  
41 ~~physician or other health care professional who is licensed in another~~  
42 ~~state and who is not licensed in this state, who is employed or under~~  
43 ~~contract with the utilization review agent and who is qualified in a~~  
44 ~~similar scope of practice as a provider, physician or other health care~~

1 ~~professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13,~~  
2 ~~14, 16, 17, 19, 19.1 or 29 or an out-of-state provider, physician or other~~  
3 ~~health care professional who is licensed in another state and who is not~~  
4 ~~licensed in this state and who typically manages the medical condition~~  
5 ~~under appeal shall review the expedited appeal and render a decision based~~  
6 ~~on the utilization review plan adopted by the utilization review~~  
7 ~~agent. Pursuant to the requirements of this subsection, the utilization~~  
8 review agent shall select ~~the A provider, physician or other health care~~  
9 ~~professional~~ who shall review the appeal and render the ~~decision~~  
10 DETERMINATION BASED ON THE UTILIZATION REVIEW PLAN ADOPTED BY THE  
11 UTILIZATION REVIEW AGENT. If the utilization review agent, ~~OR~~  
12 ~~provider, physician or other health care professional~~ denies the expedited  
13 appeal, the utilization review agent shall telephonically provide and send  
14 to the member and the member's treating provider a notice of the denial  
15 and of the member's option to immediately proceed to the external  
16 independent review prescribed in section 20-2537. FOR THE PURPOSES OF  
17 THIS SUBSECTION:

18 1. "ADVANCED PRACTICE REGISTERED NURSE" MEANS ANY OF THE FOLLOWING  
19 AS DEFINED IN SECTION 32-1601:

- 20 (a) A CERTIFIED NURSE MIDWIFE.
- 21 (b) A CERTIFIED REGISTERED NURSE ANESTHETIST.
- 22 (c) A CLINICAL NURSE SPECIALIST.
- 23 (d) A REGISTERED NURSE PRACTITIONER.

24 2. "PROVIDER" MEANS EITHER OF THE FOLLOWING:

25 (a) A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED  
26 PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR  
27 AN ADVANCED PRACTICE REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE  
28 32, CHAPTER 15, WHO IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A  
29 PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE  
30 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED  
31 PRACTICE REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15  
32 AND WHO IS EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT.

33 (b) AN OUT-OF-STATE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO  
34 IS LICENSED IN ANOTHER STATE AND WHO IS NOT LICENSED IN THIS STATE, WHO IS  
35 EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT AND WHO  
36 EITHER IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A PHYSICIAN OR OTHER  
37 HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE 32, CHAPTER 7, 8, 11,  
38 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED PRACTICE REGISTERED NURSE  
39 WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 OR WHO TYPICALLY MANAGES  
40 THE MEDICAL CONDITION UNDER APPEAL.

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

1           Sec. 5. Section 20-2535, Arizona Revised Statutes, is amended to  
2 read:

3           20-2535. Initial appeal

4           A. Any member who ~~is denied a service~~ RECEIVES AN ADVERSE  
5 DETERMINATION and who does not qualify for an expedited medical review  
6 pursuant to section 20-2534 may request, either orally or in writing, an  
7 ~~informal reconsideration~~ INITIAL APPEAL of that denial by notifying the  
8 person described in section 20-2533, subsection ~~Ē~~ H, paragraph 3. After  
9 the denial, the member has up to two years to request an ~~informal~~  
10 ~~reconsideration~~ INITIAL APPEAL. ~~A health care insurer whose utilization~~  
11 ~~review consists only of claims review for services already provided is not~~  
12 ~~required to provide its members an informal reconsideration pursuant to~~  
13 ~~this section. A health care insurer who conducts utilization review of~~  
14 ~~claims in connection with services already provided is not required to~~  
15 ~~provide its members an informal reconsideration of a claim related to a~~  
16 ~~service already provided.~~

17           ~~B. The utilization review agent shall send a written acknowledgment~~  
18 ~~to the member and the member's treating provider within five business days~~  
19 ~~after the utilization review agent receives the request for informal~~  
20 ~~reconsideration.~~

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

24           C. IF THE MEMBER'S APPEAL INVOLVES AN ISSUE OF MEDICAL NECESSITY OR  
25 APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR  
26 EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL  
27 UNDER THE COVERAGE DOCUMENT AND NOT WHETHER THE SERVICE IS COVERED, THE  
28 UTILIZATION REVIEW AGENT SHALL SELECT A PROVIDER TO REVIEW THE APPEAL AND  
29 RENDER A DETERMINATION BASED ON THE UTILIZATION REVIEW PLAN. FOR THE  
30 PURPOSES OF THIS SUBSECTION:

31           1. "ADVANCED PRACTICE REGISTERED NURSE" MEANS ANY OF THE FOLLOWING  
32 AS DEFINED IN SECTION 32-1601:

- 33           (a) A CERTIFIED NURSE MIDWIFE.
- 34           (b) A CERTIFIED REGISTERED NURSE ANESTHETIST.
- 35           (c) A CLINICAL NURSE SPECIALIST.
- 36           (d) A REGISTERED NURSE PRACTITIONER.

37           2. "PROVIDER" MEANS EITHER OF THE FOLLOWING:

- 38           (a) A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED  
39 PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR  
40 AN ADVANCED PRACTICE REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE  
41 32, CHAPTER 15, WHO IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A  
42 PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE 32,  
43 CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED PRACTICE

1 REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 AND WHO  
2 IS EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT.

3 (b) AN OUT-OF-STATE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO  
4 IS LICENSED IN ANOTHER STATE AND WHO IS NOT LICENSED IN THIS STATE, WHO IS  
5 EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT AND WHO  
6 EITHER IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A PHYSICIAN OR OTHER  
7 HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE 32, CHAPTER 7, 8, 11,  
8 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED PRACTICE REGISTERED NURSE  
9 WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 OR WHO TYPICALLY MANAGES  
10 THE MEDICAL CONDITION UNDER APPEAL.

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

17 E. At any time during the ~~informal reconsideration~~ INITIAL APPEAL  
18 process, the utilization review agent may submit a request to the director  
19 to initiate an external independent review process pursuant to section  
20 20-2537. At the same time that the utilization review agent submits the  
21 request to the director, the utilization review agent shall also render a  
22 written ~~decision~~ DETERMINATION and shall send the written ~~decision~~  
23 DETERMINATION, including the BASIS, criteria used, ~~and the~~ clinical  
24 reasons AND RATIONALE for that ~~decision~~ DETERMINATION and any references  
25 to supporting documentation, to the member, the member's treating provider  
26 and the director.

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

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

5 Sec. 6. Section 20-2536, Arizona Revised Statutes, is amended to  
6 read:

7 20-2536. Voluntary internal appeal

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

20 ~~B. The utilization review agent shall send a written acknowledgment~~  
21 ~~to the member and the member's treating provider within five business days~~  
22 ~~after the agent receives the formal appeal.~~

23 ~~C. B.~~ B. The member or the member's treating provider shall submit to  
24 the utilization review agent with the written ~~format~~ VOLUNTARY INTERNAL  
25 appeal any material justification or documentation to support the member's  
26 request for the service or claim for a service.

27 ~~D. C.~~ C. If the member's ~~complaint~~ APPEAL ~~is~~ INVOLVES an issue of  
28 medical necessity OR APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL  
29 OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR  
30 INVESTIGATIONAL under the coverage document and not whether the service is  
31 covered, ~~a provider, physician or other health care professional who is~~  
32 ~~licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1~~  
33 ~~or 29 or an out-of-state provider physician or other health care~~  
34 ~~professional who is licensed in another state and who is not licensed in~~  
35 ~~this state, who is employed or under contract with the utilization review~~  
36 ~~agent and who is qualified in a similar scope of practice as a provider,~~  
37 ~~physician or other health care professional licensed pursuant to title 32,~~  
38 ~~chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out-of-state~~  
39 ~~provider, physician or other health care professional who is licensed in~~  
40 ~~another state and who is not licensed in this state and who typically~~  
41 ~~manages the medical condition under appeal shall review the appeal and~~  
42 ~~render a decision based on the utilization review plan adopted by the~~  
43 ~~utilization review agent. Pursuant to the requirements of this~~  
44 ~~subsection,~~ the utilization review agent shall select the A

1 provider, ~~physician or other health care professional who shall~~ TO review  
2 the appeal and render ~~the decision~~ A DETERMINATION BASED ON THE  
3 UTILIZATION REVIEW PLAN ADOPTED BY THE UTILIZATION REVIEW AGENT. FOR THE  
4 PURPOSES OF THIS SUBSECTION:

5 1. "ADVANCED PRACTICE REGISTERED NURSE" MEANS ANY OF THE FOLLOWING  
6 AS DEFINED IN SECTION 32-1601:

- 7 (a) A CERTIFIED NURSE MIDWIFE.
- 8 (b) A CERTIFIED REGISTERED NURSE ANESTHETIST.
- 9 (c) A CLINICAL NURSE SPECIALIST.
- 10 (d) A REGISTERED NURSE PRACTITIONER.

11 2. "PROVIDER" MEANS EITHER OF THE FOLLOWING:

12 (a) A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED  
13 PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR  
14 AN ADVANCED PRACTICE REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE  
15 32, CHAPTER 15, WHO IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A  
16 PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE 32,  
17 CHAPTER 7, 8, 11, 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED PRACTICE  
18 REGISTERED NURSE WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 AND WHO  
19 IS EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT.

20 (b) AN OUT-OF-STATE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL WHO  
21 IS LICENSED IN ANOTHER STATE AND WHO IS NOT LICENSED IN THIS STATE, WHO IS  
22 EMPLOYED OR UNDER CONTRACT WITH THE UTILIZATION REVIEW AGENT AND WHO  
23 EITHER IS QUALIFIED IN A SIMILAR SCOPE OF PRACTICE AS A PHYSICIAN OR OTHER  
24 HEALTH CARE PROFESSIONAL LICENSED PURSUANT TO TITLE 32, CHAPTER 7, 8, 11,  
25 13, 14, 16, 17, 19, 19.1 OR 29 OR AN ADVANCED PRACTICE REGISTERED NURSE  
26 WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 OR WHO TYPICALLY MANAGES  
27 THE MEDICAL CONDITION UNDER APPEAL.

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

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

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

42 ~~F.~~ E. At any time during the ~~format~~ VOLUNTARY INTERNAL appeal  
43 process, the utilization review agent may request an external independent  
44 review process pursuant to section 20-2537. If the utilization review



1 agent initiates the external independent review process, the utilization  
2 review agent does not have to comply with subsection ~~F~~ D of this section.

3 ~~F~~ F. If at the conclusion of the ~~format~~ VOLUNTARY INTERNAL appeal  
4 process the utilization review agent denies the appeal and the utilization  
5 review agent does not initiate the external independent review process,  
6 the utilization review agent shall provide the member with notice of the  
7 option to proceed to an external independent review pursuant to section  
8 20-2537.

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

13 Sec. 7. Section 20-2537, Arizona Revised Statutes, is amended to  
14 read:

15 20-2537. External independent review; expedited external  
16 independent review

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

24 B. Except as provided in subsection ~~K~~ N of this section, A MEMBER  
25 MAY INITIATE AN EXTERNAL INDEPENDENT REVIEW within four months after the  
26 member receives written notice by the utilization review agent of ~~the~~ AN  
27 adverse ~~decision~~ DETERMINATION made pursuant to section 20-2534 or  
28 20-2536, ~~if the member decides to initiate an external independent review,~~  
29 ~~the member shall send~~ BY SENDING to the utilization review agent a written  
30 request for an external independent review, including any material  
31 justification or documentation to support the member's request for the  
32 covered service or claim for a covered service.

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

40 1. Send a written acknowledgment to the director, the member, the  
41 member's treating provider and the health care insurer. THE  
42 ACKNOWLEDGEMENT SHALL INCLUDE NOTICE TO THE MEMBER THAT THE MEMBER HAS  
43 FIVE BUSINESS DAYS AFTER RECEIVING THE NOTICE TO SUBMIT ADDITIONAL WRITTEN

1 EVIDENCE TO THE DEPARTMENT FOR CONSIDERATION BY THE ASSIGNED INDEPENDENT  
2 REVIEW ORGANIZATION.

3 2. Forward to the director the request for review, the terms of  
4 agreement in the member's policy, evidence of coverage or a similar  
5 document and all medical records and supporting documentation used to  
6 render the ~~decision~~ DETERMINATION pertaining to the member's case, a  
7 summary description of the applicable issues including a statement of the  
8 utilization review agent's ~~decision~~ DETERMINATION, the BASIS, criteria  
9 used, ~~and the~~ clinical reasons AND RATIONALE for that ~~decision~~  
10 DETERMINATION, the relevant portions of the utilization review agent's  
11 utilization review plan and the name and credentials of the licensed  
12 health care provider who reviewed the case as required by section 20-2533,  
13 subsection ~~G~~ L.

14 D. Except as provided in subsection ~~K~~ N of this section, within  
15 five days after the director receives all of the information prescribed in  
16 subsection C, paragraph 2 of this section and if the case involves an  
17 issue of medical necessity OR APPROPRIATENESS, INCLUDING HEALTH CARE  
18 SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS  
19 EXPERIMENTAL OR INVESTIGATIONAL under the coverage document, the director  
20 shall choose an independent review organization procured pursuant to  
21 section 20-2538 and forward to the organization all of the information  
22 required by subsection C, paragraph 2 of this section.

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

30 ~~E~~. F. Except as provided in subsection ~~K~~ N of this section, for  
31 cases involving an issue of medical necessity OR APPROPRIATENESS,  
32 INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A COVERED  
33 BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL under the coverage  
34 document, within twenty-one days after the date of receiving a case for  
35 independent review from the director, the independent review organization  
36 shall evaluate and analyze the case and, based on all information required  
37 under subsection C, paragraph 2 of this section, render a ~~decision~~  
38 DETERMINATION that is consistent with the utilization review plan on  
39 whether or not the service or claim for the service is medically necessary  
40 OR APPROPRIATE, INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR  
41 EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL  
42 and send the ~~decision~~ DETERMINATION to the director. ~~Within five business~~  
43 ~~days after receiving a notice of decision from the independent review~~  
44 ~~organization, the director shall send a notice of the decision to the~~

~~utilization review agent, the health care insurer, the member and the member's treating provider. The decision 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.~~

G. THE INDEPENDENT REVIEW ORGANIZATION'S DETERMINATION PURSUANT TO SUBSECTION F OF THIS SECTION SHALL BE CONSISTENT WITH THE UTILIZATION REVIEW PLAN AND IN ACCORDANCE WITH THE FOLLOWING:

1. THE INDEPENDENT REVIEW ORGANIZATION REVIEWER SHALL CONSIDER THE FOLLOWING INFORMATION IN RENDERING A DETERMINATION, AS APPROPRIATE AND AVAILABLE UNDER THE CIRCUMSTANCES:

- (a) THE MEMBER'S PERTINENT MEDICAL RECORDS.
- (b) THE TREATING PROVIDER'S RECOMMENDATION.
- (c) ANY CONSULTING REPORT FROM A HEALTH CARE PROFESSIONAL.
- (d) ANY DOCUMENT SUBMITTED BY A HEALTH CARE INSURER OR MEMBER.
- (e) FOR CLAIMS OR REQUESTS FOR SERVICES DENIED FOR REASONS OTHER

THAN AS EXPERIMENTAL OR INVESTIGATIONAL, THE INDEPENDENT REVIEW ORGANIZATION SHALL ALSO CONSIDER:

(i) THE MOST APPROPRIATE PRACTICE GUIDELINES, WHICH SHALL INCLUDE APPLICABLE EVIDENCE-BASED STANDARDS AND MAY INCLUDE ANY OTHER PRACTICE GUIDELINES DEVELOPED BY THE FEDERAL GOVERNMENT, NATIONAL OR PROFESSIONAL MEDICAL SOCIETIES, BOARDS AND ASSOCIATIONS.

(ii) ANY APPLICABLE CLINICAL REVIEW CRITERIA DEVELOPED AND USED BY THE HEALTH CARRIER OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION.

(iii) THE OPINION OF THE INDEPENDENT REVIEW ORGANIZATION'S CLINICAL REVIEWER OR REVIEWERS AFTER CONSIDERING SUBDIVISIONS (a) THROUGH (d) AND SUBDIVISION (e), ITEMS (i) AND (ii) OF THIS PARAGRAPH TO THE EXTENT THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE CLINICAL REVIEWER OR REVIEWERS CONSIDER APPROPRIATE.

(f) FOR CLAIMS OR REQUESTS FOR SERVICES DENIED AS EXPERIMENTAL OR INVESTIGATIONAL, THE INDEPENDENT REVIEW ORGANIZATION SHALL ALSO CONSIDER THE TERMS OF COVERAGE UNDER THE MEMBER'S POLICY WITH THE HEALTH CARE INSURER TO ENSURE THAT EXCEPT FOR A HEALTH CARE INSURER'S DETERMINATION FOR AN EXPERIMENTAL OR INVESTIGATIONAL SERVICE, THE REVIEWER'S OPINION IS NOT CONTRARY TO THE TERMS OF COVERAGE AND ANY OF THE FOLLOWING:

(i) WHETHER THE SERVICE HAS BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR THE CONDITION.

(ii) WHETHER THE MEDICAL OR SCIENTIFIC EVIDENCE OR EVIDENCE-BASED STANDARDS DEMONSTRATE THAT THE EXPECTED BENEFIT OF THE SERVICE IS MORE LIKELY THAN NOT TO BE BENEFICIAL TO THE MEMBER THAN ANY AVAILABLE STANDARD

1 SERVICE AND THAT ANY ADVERSE RISK IS NOT SUBSTANTIALLY INCREASED OVER  
2 ADVERSE RISKS OF AVAILABLE STANDARD SERVICES.

3 2. THE INDEPENDENT REVIEW ORGANIZATION REVIEWER'S WRITTEN  
4 DETERMINATION SHALL INCLUDE:

5 (a) A DESCRIPTION OF THE COVERED PERSON'S MEDICAL CONDITION.

6 (b) A DESCRIPTION OF THE INDICATORS RELEVANT TO DETERMINING WHETHER  
7 THERE IS SUFFICIENT EVIDENCE TO DEMONSTRATE THAT THE EXPECTED BENEFIT OF  
8 THE SERVICE IS MORE LIKELY THAN NOT TO BE BENEFICIAL TO THE MEMBER THAN  
9 ANY AVAILABLE STANDARD SERVICE AND THAT ANY ADVERSE RISK IS NOT  
10 SUBSTANTIALLY INCREASED OVER ADVERSE RISKS OF AVAILABLE STANDARD SERVICES.

11 (c) A DESCRIPTION AND ANALYSIS OF ANY MEDICAL OR SCIENTIFIC  
12 EVIDENCE CONSIDERED IN REACHING THE DETERMINATION.

13 (d) A DESCRIPTION AND ANALYSIS OF ANY EVIDENCE-BASED STANDARD.

14 (e) INFORMATION ON WHETHER THE REVIEWER'S RATIONALE FOR THE  
15 DETERMINATION IS BASED ON PARAGRAPH 1, SUBDIVISION (e), ITEMS (i) AND (ii)  
16 OF THIS SUBSECTION.

17 H. WITHIN FIVE BUSINESS DAYS AFTER RECEIVING A NOTICE OF  
18 DETERMINATION FROM THE INDEPENDENT REVIEW ORGANIZATION, THE DIRECTOR SHALL  
19 SEND NOTICE OF THE DETERMINATION TO THE UTILIZATION REVIEW AGENT, THE  
20 HEALTH CARE INSURER, THE MEMBER AND THE MEMBER'S TREATING PROVIDER. THE  
21 DETERMINATION IS A FINAL ADMINISTRATIVE DECISION PURSUANT TO TITLE 41,  
22 CHAPTER 6, ARTICLE 10 AND IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE  
23 12, CHAPTER 7, ARTICLE 6. THE HEALTH CARE INSURER SHALL PROVIDE ANY  
24 SERVICE OR PAY ANY CLAIM DETERMINED TO BE COVERED AND MEDICALLY NECESSARY  
25 BY THE INDEPENDENT REVIEW ORGANIZATION FOR A CASE UNDER REVIEW WITHOUT  
26 DELAY REGARDLESS OF WHETHER JUDICIAL REVIEW IS SOUGHT.

27 ~~F.~~ I. Except as provided in subsection ~~K~~ N of this section, for  
28 cases involving an issue of coverage, within fifteen business days after  
29 receipt of all of the information prescribed in subsection C, paragraph 2  
30 of this section from the utilization review agent, the director shall  
31 determine if the service or claim is or is not covered and if the adverse  
32 ~~decision~~ DETERMINATION made pursuant to section 20-2536 conforms to the  
33 utilization review agent's utilization review plan and this article and  
34 shall send a notice of determination to the utilization review agent, the  
35 health care insurer, the member and the member's treating provider.

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

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

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

3           2. To issue a final administrative decision pursuant to section  
4 41-1092.08.

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

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

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

26           1. Within ~~five business days~~ FOUR MONTHS after the member receives  
27 written notice by the utilization review agent of the adverse ~~decision~~  
28 DETERMINATION made pursuant to section 20-2534, if the member decides to  
29 initiate an external independent review, the member shall send to the  
30 utilization review agent a written request for an expedited external  
31 independent review, including any material justification or documentation  
32 to support the member's request for the covered service or claim for a  
33 covered service. FOR AN ADVERSE DETERMINATION INVOLVING AN EXPERIMENTAL  
34 OR INVESTIGATIONAL SERVICE, A MEMBER MAY MAKE AN ORAL REQUEST IF THE  
35 MEMBER'S TREATING PHYSICIAN CERTIFIES IN WRITING THAT THE RECOMMENDED  
36 SERVICE OR TREATMENT WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY  
37 INITIATED.

38           2. Within one business day after the utilization review agent  
39 receives a request for an expedited external independent review from the  
40 member pursuant to this subsection or if the utilization review agent  
41 initiates an expedited external independent review pursuant to section  
42 20-2534, subsection D, the utilization review agent shall:

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

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

12 3. Within two business days after the director receives all of the  
13 information prescribed in this subsection and if the case involves an  
14 issue of medical necessity OR APPROPRIATENESS, INCLUDING HEALTH CARE  
15 SETTING, LEVEL OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS  
16 EXPERIMENTAL OR INVESTIGATIONAL, the director shall choose an independent  
17 review organization procured pursuant to section 20-2538 and forward to  
18 the organization all of the information required by this subsection.

19 4. For cases involving an issue of medical necessity OR  
20 APPROPRIATENESS, INCLUDING HEALTH CARE SETTING, LEVEL OF CARE OR  
21 EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR INVESTIGATIONAL,  
22 within seventy-two hours from the date of receiving a case for expedited  
23 external independent review from the director, the independent review  
24 organization shall evaluate and analyze the case and, based on all  
25 information required under subsection C, paragraph 2 of this section,  
26 render a ~~decision~~ DETERMINATION that is consistent with the utilization  
27 review plan on whether or not the service or claim for the service is  
28 medically necessary OR APPROPRIATE, INCLUDING HEALTH CARE SETTING, LEVEL  
29 OF CARE OR EFFECTIVENESS OF A COVERED BENEFIT, OR IS EXPERIMENTAL OR  
30 INVESTIGATIONAL and send the ~~decision~~ DETERMINATION to the director.  
31 Within one business day after receiving a notice of ~~decision~~ DETERMINATION  
32 from the independent review organization, the director shall send a notice  
33 of the ~~decision~~ DETERMINATION to the utilization review agent, the health  
34 care insurer, the member and the member's treating provider. The ~~decision~~  
35 DETERMINATION by the independent review organization is a final  
36 administrative decision pursuant to title 41, chapter 6, article 10 and,  
37 except as provided in section 41-1092.08, subsection H, is subject to  
38 judicial review pursuant to title 12, chapter 7, article 6. The health  
39 care insurer shall provide any service or pay any claim determined to be  
40 covered and medically necessary by the independent review organization for  
41 the case under review regardless of whether judicial review is sought.

42 5. For cases involving an issue of coverage, within two business  
43 days after receipt of all of the information prescribed in subsection C of  
44 this section from the utilization review agent, the director shall

1 determine if the service or claim is or is not covered and if the adverse  
2 ~~decision~~ DETERMINATION made pursuant to section 20-2534 conforms to the  
3 utilization review agent's utilization review plan and this article and  
4 shall send a notice of determination to the utilization review agent, the  
5 health care insurer, the member and the member's treating provider.

6 ~~L.~~ O. Notwithstanding title 41, chapter 6, article 10 and section  
7 12-908, if a party to a decision issued under this section seeks further  
8 administrative review, the department shall not be a party to the action  
9 unless the department files a motion to intervene in the action.

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

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

21 Sec. 8. Title 20, chapter 15, article 2, Arizona Revised Statutes,  
22 is amended by adding section 20-2542, to read:

23 20-2542. Recordkeeping

24 A HEALTH CARE INSURER AND AN INDEPENDENT REVIEW ORGANIZATION SHALL  
25 MAINTAIN ALL RECORDS RELATED TO INTERNAL AND EXTERNAL APPEALS AND  
26 EXCEPTION REQUESTS FOR AT LEAST THREE YEARS AFTER THE COMPLETION OF THE  
27 APPEALS PROCESS OR EXCEPTION REQUEST PROCESS.

28 Sec. 9. Effective date

29 This act is effective from and after December 31, 2024.

APPROVED BY THE GOVERNOR APRIL 23, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 23, 2024.