REFERENCE TITLE: utilization review; health care appeals

State of Arizona
House of Representatives
Fifty-seventh Legislature
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2025

HB 2900

Introduced by
Representatives Austin: Abeytia, Aguilar, Blattman, Crews, Garcia, Sandoval

AN ACT

AMENDING SECTIONS 20-2535, 20-2536 AND 20-2537, ARIZONA REVISED STATUTES; 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 20-2535, Arizona Revised Statutes, is amended to read:

20-2535. Initial appeal

A. Any member who receives an adverse determination and who does not qualify for an expedited medical review pursuant to section 20-2534 may request, either orally or in writing, an initial appeal of that denial by notifying the person described in section 20-2533, subsection H, paragraph 3. After the denial, the member has up to two years to request an initial appeal.

B. THE UTILIZATION REVIEW AGENT SHALL SEND 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 INITIAL APPEAL.

~~B.~~ 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 initial appeal.

~~C.~~ D. If the member's appeal involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, the utilization review agent shall select a provider to review the appeal and render a determination based on the utilization review plan. For the purposes of this subsection:

1. "Advanced practice registered nurse" means any of the following as defined in section 32-1601:

(a) A certified nurse midwife.

(b) A certified registered nurse anesthetist.

(c) A clinical nurse specialist.

(d) A registered nurse practitioner.

2. "Provider" means either of the following:

(a) A 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 advanced practice registered nurse who is licensed pursuant to title 32, chapter 15, who is qualified in a similar scope of practice as a 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 advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 and who is employed or under contract with the utilization review agent.

(b) An out-of-state 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 either is qualified in a similar scope of practice as a 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 advanced practice registered nurse

who is licensed pursuant to title 32, chapter 15 or who typically manages the medical condition under appeal.

~~D.~~ E. Within the time frames prescribed in section 20-2533, subsections C and D, the utilization review agent shall send 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.

~~E.~~ F. At any time during the 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 determination and shall send the written determination, including the basis, criteria used, clinical reasons and rationale for that 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 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, clinical reasons and rationale for that determination, including any references to any supporting documentation. The determination shall include a notice of the option to proceed to the voluntary internal appeal process pursuant to section 20-2536 for a group health plan or grandfathered individual 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 health care insurer 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 determination.

Sec. 2. Section 20-2536, Arizona Revised Statutes, is amended to read:

20-2536. Voluntary internal appeal

A. For a group health plan, or a grandfathered individual plan, if a health care insurer elects to include as part of its internal review levels a voluntary internal appeal level after any applicable initial appeal pursuant to section 20-2535 and the utilization review agent denies the member's initial request, the member may appeal that adverse determination to the voluntary internal appeal level. The member shall send a written appeal to the utilization review agent within sixty days after receipt of the adverse determination.

B. THE UTILIZATION REVIEW AGENT SHALL SEND A WRITTEN ACKNOWLEDGMENT TO THE MEMBER AND THE MEMBER'S TREATING PROVIDER WITHIN FIVE BUSINESS DAYS AFTER THE AGENT RECEIVES THE VOLUNTARY INTERNAL APPEAL.

~~B.~~ C. The member or the member's treating provider shall submit to the utilization review agent with the written voluntary internal appeal any material justification or documentation to support the member's request for the service or claim for a service.

~~C.~~ D. If the member's appeal involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, the utilization review agent shall select a provider to review the appeal and render a determination based on the utilization review plan adopted by the utilization review agent. For the purposes of this subsection:

1. "Advanced practice registered nurse" means any of the following as defined in section 32-1601:

(a) A certified nurse midwife.

(b) A certified registered nurse anesthetist.

(c) A clinical nurse specialist.

(d) A registered nurse practitioner.

2. "Provider" means either of the following:

(a) A 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 advanced practice registered nurse who is licensed pursuant to title 32, chapter 15, who is qualified in a similar scope of practice as a 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 advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 and who is employed or under contract with the utilization review agent.

(b) An out-of-state 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 either is qualified in a similar scope of practice as a 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 advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 or who typically manages the medical condition under appeal.

~~D.~~ E. Except as provided in subsection ~~E~~ F of this section, the utilization review agent shall send 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.

~~E.~~ F. At any time during the 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 ~~D~~ E of this section.

~~F.~~ G. If at the conclusion of the 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.

~~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 determination.

Sec. 3. 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 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 N 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 an adverse determination made pursuant to section 20-2534 or 20-2536 by sending 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 N 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 J of this section, or if the utilization review agent initiates an external independent review pursuant to section 20-2536, subsection ~~F~~ G, the utilization review agent shall:

1. Send 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 receiving 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 determination pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's determination, the basis, criteria used, clinical reasons and rationale for that 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 L.

D. Except as provided in subsection N 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 or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational 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 and in its discretion may consider evidence submitted after five business days.

F. Except as provided in subsection N of this section, for cases involving an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational 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 determination that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary or appropriate, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational and send the determination to the director.

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 service and that any adverse risk is not substantially increased over adverse risks of available standard services.

2. The independent review organization reviewer's written determination shall include:

(a) A description of the covered person's medical condition.

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the expected benefit of the service is more likely than not to be beneficial to the member than any available standard service and that any adverse risk is not substantially increased over adverse risks of available standard services.

(c) A description and analysis of any medical or scientific evidence considered in reaching the determination.

(d) A description and analysis of any evidence-based standard.

(e) Information on whether the reviewer's rationale for the determination is based on paragraph 1, subdivision (e), items (i) and (ii) of this subsection.

H. Within five business days after receiving a notice of determination from the independent review organization, the director shall send notice of the determination to the utilization review agent, the health care insurer, the member and the member's treating provider. The determination 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 a case under review without delay regardless of whether judicial review is sought.

I. Except as provided in subsection N 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 determination made pursuant to section 20-2536 conforms to the utilization review agent's utilization review plan and this article and shall send a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

J. 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 F and N of this section.

K. After a determination is made pursuant to subsection F, I, J or N of this section, the appeals 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.

L. Except as provided in subsection N 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 F of this section for up to an additional ten days if the requesting party demonstrates good cause for an extension.

M. A 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.

N. 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 been discharged or denies, reduces or terminates coverage for a member's admission, the availability of care, a continued stay for a course of treatment before the end of the period of

time or number of treatments recommended by the treating provider, or if a member exhausted or the health care insurer has waived the health care insurer's internal levels of review pursuant to section 20-2533, subsections F and G, the member may initiate an expedited external independent review in accordance with the following:

1. Within four months after the member receives written notice by the utilization review agent of the adverse determination made pursuant to section 20-2534, if the member decides to initiate an external independent review, the member shall send 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. For an adverse determination involving an experimental or investigational service, a member may make an oral request if the member's treating physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated.

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) Send 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 determination pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's determination, the basis, criteria used clinical reasons and rationale for that 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 or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational, 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 or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational, 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 determination that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary or appropriate, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational and send the determination to the director. Within one business day after receiving a notice of determination from the independent review organization, the director shall send a notice of the determination to the utilization review agent, the health care insurer, the member and the member's treating provider. The 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 determination made pursuant to section 20-2534 conforms to the utilization review agent's utilization review plan and this article and shall send a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

O. 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.

P. 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.

Q. 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 N of this section shall be promptly instituted and completed.