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EmR1117

The statement of scope for this rule, SS ch Ins 18, was approved by the governor on Sept. 30, 2011, published in the Register # 670, on October 14, 2011, and approved by the Commissioner Theodore Nickel on October 26, 2011. The Emergency rule was approved by the Governor on November 3, 2011.

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING, AMENDING, REPEALING AND RECREATING AND CREATING A RULE

To repeal Ins 18.10 (1), (2) (d) and (3), 18.12 (1) (b) 4.;

To renumber Ins 18.01, 18.015 (1);

To amend Ins 18 chapter (title), subch. I (title), 18.015 (4) (intro.) and (e), (8) and (10), 18.03 (1) (a) to (c), (2) (a), (b), (c) 1., 2. (intro.), c. and (d), (3) (title), (3) (intro.), (4), (5) (a) (intro.), (b) (intro.), (c) and (d), (6) (intro.), (b) (intro.), and (7), 18.04, 18.05, 18.06 (intro.) and (1), 18.10 (intro.), (2) (intro.) (b) and (c), 18.11 (1), (2) (intro.), (a) and (b), (3) (intro.), (3), (4) (a), 18.12 (1) (intro.), (a) 1., (b) 1. and 2., (e) (intro.), 1., 3., and 4., and (f) to (j), 18.13 (1), 18.14 (1), 18.16 (1), (2) (b), (c) and (i), 18.18 (3);

To repeal and recreate Ins 18.02 and 18.105; and

To create Ins 18.01, 18.015 (1), (1m), (2r), (3g), (3r), (4g), (4r), (7m), (9g), (9r), (11) and (12), 18.035, 18.0357, 18.11 (1m), (2) (a) 1., 6. am., and c., and 7., and (3) (cm), Wis. Adm. Code,

Relating to grievances and independent review requirements and affecting small business.

FINDING OF EMERGENCY

The Commissioner of Insurance finds that an emergency exists and that the attached proposed emergency rule is necessary for the immediate preservation of the public peace, health, safety, or welfare. Portions of Wisconsin's insurance law and regulations governing grievances and independent review processes are in conflict with federal law and regulation following the amendment of 42 USC 300gg 19 (a) and (b), as implemented by 45 CFR 147.136, as amended. Therefore, the Commissioner, pursuant to s. 631.01 (5), Stats., has determined that it is in the interest of the State of Wisconsin, Wisconsin insureds and the public to exempt insurers, certified independent review organizations and self-insured governmental health plans that elect to comply with ch. Ins 18, Wis. Adm. Code, as revised, from being required to comply with provisions contained in s. 632.83 and 632.835, Stats., that are inconsistent with 42 USC 300gg-19 (a) and (b), and 45 CFR 147.136 et seq., as amended.

Facts constituting the emergency arise from the desire for the State of Wisconsin to retain jurisdiction and regulatory control over the grievance and the independent review processes and independent review organizations operating in the state. The Secretary of the US Department of Health and Human Services issued interim final regulations and guidance, most recently released late June 2011. The regulations require states that desire to retain regulatory oversight of the grievance and independent external review processes, to demonstrate compliance with the federal internal appeal and external review laws and regulations to the Center for Consumer Information and Insurance Oversight ("CCIIO"). The Commissioner received notice on July 29, 2011, from CCIIO that Wisconsin's current regulatory oversight is not compliant.

The Commissioner has requested reconsideration of that initial determination, however, to ensure retention of regulatory oversight of the grievance and independent external review processes revisions to ch. Ins 18, Wis. Adm. Code, must be made and be applicable for claims arising on or after January 1, 2012. Assembly Bill 210 has been introduced, a bill that repeals inconsistent provisions in accordance with federal requirements, but it is unlikely that AB 210 will be enrolled within the reconsideration timeframe. Therefore the Commissioner is proposing this

emergency rule to comply with the federal requirements in order to retain regulatory jurisdiction of grievance and independent review processes.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 600.01, 628.34 (12), 631.01 (5), 632.73, 632.76, 632.81, 632.83, 632.835, and 632.84, Stats.

2. Statutory authority:

ss. 600.01 (2), 601.41 (3), 628.34 (12), 631.01 (5), 632.73, 632.76, 632.81, 632.835 (5) and (8), and 632.84, Stats.

3. Explanation of OCI's authority to promulgate the proposed rule under these statutes:

The OCI has authority to promulgate rules interpreting s. 632.83 and 632.835, Stats., implementing grievance and independent review requirements and procedures. In addition s. 632.835, Stats., permits the OCI to promulgate rules for the certification of independent review organizations. Section 631.01 (5), Stats., permits the Commissioner to exempt insurers, independent review organizations and the public from regulations contained in chs. 631 and 632, Stats., through rule if the interests of Wisconsin insureds or creditors or of the public do not require such regulation.

The interests of Wisconsin insureds and the public will be best served if provisions inconsistent with federal law and regulation are not enforced as that will permit the state to comply with federal requirements governing internal appeals and independent review of coverage denial determinations; allow insurers and independent review organizations to amend policy forms and procedures that fully comply prior to January 1, 2012; and retain regulatory jurisdiction over the grievance and independent review processes.

4. Related statutes or rules:

None.

5. The plain language analysis and summary of the proposed rule:

The proposed emergency rule modifies ch. Ins 18 to comply with 42 USC 300gg-19 (a) and (b), as amended, and as implemented in regulations issued by the Secretary of the US Department of Health and Human Services as contained in part at 45 CFR 147.136, as amended. Federal law and regulations incorporate portions of the Department of Labor regulations and portions of the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act ("NAIC Model Act").

The federal law is applicable in Wisconsin beginning January 1, 2012, as Wisconsin currently has a grievance and independent review process. However, Wisconsin will lose the ability to regulate grievance and independent review processes if ch. Ins 18, Wis. Adm. Code, and s. 632.83 and 632.835, Stats., are not in compliance with the federal law and regulations as determined by the CCIIO. This proposed emergency rule will bring Wisconsin regulations into compliance and relieve insurers and independent review organizations from complying with inconsistent provisions of s. 632.83 and 632.835, Stats.

In subch. I, the proposed emergency rule adds definitions of recently passed federal legislation and corresponding regulations. Subch. I combines terms from subch. III within one section that apply to both grievances and independent review for ease of use and consistency. Modifications include the amending experimental treatment determinations and adverse benefit determinations. In addition s. Ins 18.035 is created to differentiate those issues that may be grieved and not subject to federal requirements from those grievances that involve coverage denial determinations that related to medical necessity, appropriateness, health care setting, level of care or effectiveness determinations, preexisting condition exclusion denial determinations, determinations to rescind or reform a policy or experimental treatment determinations that need to comply with the federal requirements.

Under current law, insureds are able to file complaints and grievances on any issue including administration of insurance plans. While retaining this right to complain and grieve, the proposed emergency rule separates grievances that are subject to independent review from those that are not. Section Ins 18.105 describes grievances involving coverage denial determinations that are based on specific criteria as eligible for independent review. This distinction is clarified in subch. II amendments. Grievances involving coverage denial determinations that relate to medical necessity, health care setting, appropriateness and level of care, preexisting condition denial determination,

experimental treatment denial determination, and rescissions or reformations are eligible for independent review. Coverage denial determinations may also include urgent care benefit requests and related grievance of the determination. In comparison, a complaint or grievance related to administration of the plan by an insurer is not eligible for independent review but may be grieved.

Differences between the grievance processes for administrative issues versus coverage denial determinations include: the grievance involving coverage denial determinations require the insured or insured's authorized representative be given the opportunity to present evidence and testimony at a grievance hearing while although the insured or insured authorized representative may be present during a panel discussion of the grievance, the insured or insured's authorized representative must present information or evidence through written submission to the panel. Timeframes for completion of a grievance also varies depending on whether or not the grievance relates to a coverage denial determination with grievances involving coverage denial determinations needing to be completed in no more than 60 days from receipt of the request to grieve.

The proposed emergency rule amends the requirements for the content of notices to reflect additional information regarding an insured's right to request a grievance involving a coverage denial determination. Such grievance notice must allow the insured or the insured authorized representative to provide additional information, evidence and testimony. The insured or the insured's authorized representative is required to receive copies free of charge of any records or evidence the insurer used or the grievance panel used in rendering its denial or decision.

Subchapter II repeals the financial threshold requirement, as it is inconsistent with federal law. Federal law requires that insureds are to have no barrier to filing an appeal of a coverage denial determination. The proposed rule creates s. Ins 18.0357 to implement an insured's right to request a determination for urgent care services both on a standard and expedited basis. A claim involving urgent care benefit determination may also be grieved and the insured also has a right to an independent review. Expedited grievances must be completed as urgently as the insured's medical condition warrants but in no instance may the appeal exceed 72 hours from receipt of the request.

Subchapter II and III have been modified to ensure both grievances and independent review of experimental treatment denial determinations comply with federal requirements including the NAIC Model Act section 10. Modifications include certification from a physician familiar with the insured that standard treatment have not been effective in improving the condition of the insured; that standard care or has not been effective; and experimental treatment would be more beneficial than alternative covered treatments available.

Subchapter III addresses the independent review process and requirements for independent review organizations. Independent review are available to insureds who have received final coverage denial determinations including determinations that relate to medical necessity, health care setting, appropriateness and level of care, preexisting condition denial determinations, experimental treatment denial determinations and rescissions or reformation of coverage determinations unless an exception applies.

Newly proposed s. Ins 18.11 (1m) describes the manner of selecting independent review organizations. To be compliant with federal requirements, the office must assign the organization on a random or rotational basis to ensure impartiality and independence of the review. As a result of this new process of selection, s. Ins 18.11 (1m), is in incorporated into the rule requiring insurers to contact the office and complete an online application, the result of which is a random, impartial assignment of an independent review organization certified to operate in Wisconsin. The selected independent review organization must determine if it has any conflicts of interest and if so is required to have a procedure in place to contact the office, insurer and insured or the insured's authorized representative so that the insurer may request assignment of a different review organization.

The independent review timeframes have been modified to comply with federal timeframes. Independent reviews must be completed within 45-days from receipt of the request. Insureds or their authorized representatives must receive all information that is provided to the organization and may provide additional information that must be considered prior to issuing a decision.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

Amendments to the Public Health Service Act (42 USC 300gg-19 (a) and (b)) created an internal appeal and external review right for consumers covered by group or individual health insurance. Section 2719 of the Public Health Service Act is implemented by interim final rules and guidance as issued by the US Department of Health and Human Services. The regulation found in part at 45 CFR 147.136, as amended, permits states to continue regulating

internal appeals and external review of adverse benefit determinations including rescissions, preexisting condition denial determinations and experimental treatment determinations provided the regulations are in compliance with federal regulation largely reflective of the NAIC Model Act.

The regulations promulgated by the DHHS, established two tracks; NAIC parallel and NAIC similar. The NAIC parallel process must be operational no later than January 1, 2014. For states needing more time to implement all provisions, an intermediary step is the NAIC similar process. Since Wisconsin has provisions similar to the NAIC parallel requirements the proposed emergency rule implements those additional or modified approaches.

7. Comparison of similar rules in adjacent states as found by OCI:

Illinois: Effective August 26, 2011, Illinois passed House Bill 224 father implementing PPACA by including provisions for preexisting conditions and rescissions and modifying review timeframes to comply with federal requirements. This builds on Illinois' managed care reform and patients right act 215 ILCS 134, initiating external review for insured enrolled in health maintenance organizations a right to external review of medical necessity determinations. Also on January 5, 2010, Illinois enacted the health carrier external review act that broadens the right to external review to all Illinois residents enrolled in health insurance plans under 215 ILCS 180.

Iowa: Effective March 23, 2011, Iowa enacted House File 597 to enact new procedures for external review in order to comply with federal law. Iowa updated its regulations 191- ch. 76 effective July 8, 2011 and is compliant with federal requirements.

Michigan: Effective October 1, 2000, Michigan offers external review for adverse determinations based upon medical necessity that are unresolved internally by the plan. 2000 PA 251, MCL 550.1911. Is compliant with federal requirements

Minnesota: Effective 2000 Minnesota enacted law that provider external review relating to medical necessity determinations from managed care plans and indemnity carriers. Minn. Stat. 72A.327. Is compliant with federal requirements

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The office reviewed state and federal law and regulations that reflect the NAIC Model Act and the Department of Labor's regulations for ERISA plans. Insurers and independent review organizations are required to comply with the federal requirements as set forth in this emergency rule. This rule reflects the requirements set forth by the federal government and should allow the state to retain regulatory jurisdiction as opposed to the federal government.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

The independent review organizations are certified by the commissioner's designee to conduct independent reviews in the state and several are small businesses. The additional cost for complying with this rule is no different for an independent review organization cost for complying with the federal law. Further, if there is additional cost it will be primarily borne by large insurers who are required by federal law to pay for the cost of an independent review, not the independent review organizations. The proposed rule places few additional requirements on the independent review organizations and in clarifying what is and is not eligible for reviews, the costs incurred will be limited.

10. See the attached Private Sector Fiscal Analysis.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm** or by contacting Inger Williams, OCI Services Section, at:

Phone: (608) 264-8110
Email: inger.williams@wisconsin.gov

Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on the 14th day after the date for the hearing stated in the Notice of Hearing.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins ch 18
Office of the Commissioner of Insurance
PO Box 7873
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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Ins 18 chapter (title) and subch. I (title) are amended to read:

Ins 18 chapter title. ~~HEALTH BENEFIT PLAN~~GROUP AND INDIVIDUAL HEALTH INSURANCE COVERAGE GRIEVANCES AND INDEPENDENT REVIEW ORGANIZATIONS CERTIFICATION AND REVIEW PROCEDURES.

Subchapter I — Authority, Scope and Definitions

SECTION 2. Ins 18.01 is renumbered 18.015.

SECTION 3. Ins 18.01 is created to read:

Ins 18.01 Authority and Scope. (1) This chapter is promulgated pursuant to the authority granted by ss. 601.41 (3), 631.01 (5), and 632.835, Stats.

(2) Notwithstanding any inconsistent provisions of s. 632.83 or 632.835, Stats., insurers offering group or individual health insurance coverage subject to and in compliance with s. 2719 (a) (1) or (b) (1) of the Public Health Service Act (42 USC 300gg-19 (a) (1) or (b) (1)), 45 CFR 147.136 (b) and (c), as amended, and that are also in compliance with applicable provisions of this chapter, shall be exempt from complying with any inconsistent provisions of s. 632.83 and 632.835, Stats.

(3) Self-insured governmental health plans may elect to either comply with federal or state process for grievance and independent reviews.

SECTION 4. Ins 18.015 (1) is renumbered (1g).

SECTION 5. Ins 18.015 (1), (1r), (2r), (3g), (3r), (4g), (4r), (7m), (9g), (9r) (11) and (12) are created to read:

(1) "Adverse determination" means a denial, reduction, or termination of, or failure to provide or make payment, in whole or in part for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or not medically necessary or appropriate as provided in 29 CFR 2560.503-1. "Adverse determination" includes any of the following:

(a) The determination by an insurer offering group or individual health insurance coverage that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon

the information provided, does not meet the health insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

(b) Any rescission of coverage, as provided in 45 CFR s. 147.136 (b) (2) (ii) (A), as amended, whether or not the rescission has an adverse effect on any particular benefit at that time.

(c) The denial of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer's provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network.

(d) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part, for a benefit.

(1m) "De minimis violation" means a violation of the grievance process and timeframes that does not cause, and are not likely to cause, prejudice or harm the insured so long as the insurer demonstrates that the violation was for good cause or due to matters beyond the control of the insurer and that the violation occurred in the context of an ongoing, good faith exchange of information between the insurer and insured. "De minimis violation" exception is not available if the violation is a part of a pattern or practice of violations by the insurer.

(3g) "Grandfathered health plan" has the meaning given in section 1251 (e) of the Patient Protection and Affordable Care Act.

(3r) "Final coverage determination" means a coverage denial determination that has been upheld by the insurer offering group or individual health insurance coverage at the completion of a grievance process or a coverage denial determination that with respect to which the grievance process has been deemed by an independent review organization to be exhausted in accordance with s. 18.11 (2) (a) 6. c.

(4g) "Group or individual health insurance coverage" means group and individual health insurance coverage subject to section 2791 of the Public Health Service Act (42 USC 300gg-91 (b) (4) and (5)),as amended, and includes a health benefit plan.

(4r) "Health benefit plan" has the meaning provided in s. 632.83 (1) and 632.835 (1) (c), Stats., as applicable, and includes Medicare supplement and Medicare replacement plans as defined in s. 600.03 (28p) and (28r), Stats., and s. Ins 3.39 (3) (v) and (w). Health benefit plan includes Medicare cost and select plans but does not include Medicare Advantage plans.

(7m) "Limited-scope dental or vision benefits" means limited-scope dental or vision benefits provided under a separate policy, certificate, or contract of insurance or plan, or otherwise not provided as an integral part of the policy, certificate, or contract of insurance or plan.

(9g) "Patient Protection and Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

(9r) "Public Health Service Act" means the federal Public Health Services Act of 1944, as amended, including by the Patient Protection and Affordable Care Act (42 USC 300gg et seq.).

(11) "Self-insured governmental health plan" means a self-insured health plan of the state or a county, city, village, town or school district.

(12) "Urgent care claim" means a claim for medical care or treatment when any of the following applies:

(a) The duration of the standard resolution process will result in serious jeopardy to the life or health of the insured or the ability of the insured to regain maximum function.

(b) In the opinion of a physician with knowledge of the insured's medical condition, would subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(c) A physician with knowledge of the insured's medical condition determines that the coverage determination shall be treated as an expedited benefit determination.

SECTION 6. Ins 18.015 (4) (intro.) and (e), (8), and (10) are amended read:

(4) "Grievance" means any dissatisfaction with an insurer offering ~~a health benefit plan~~ group or individual health insurance coverage or administration of ~~a health benefit plan~~ group or individual health insurance coverage by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including any of the following:

(e) Determination of experimental treatment or preexisting condition coverage.

(8) "OCI complaint" means any complaint received by the office of the commissioner of insurance by, or on behalf of, an insured of an insurer offering ~~coverage under a health benefit plan~~ group or individual health insurance coverage.

(10) "Rescission" or "reformation" of a policy means a determination by an insurer offering ~~health benefit plan~~group or individual health insurance coverage, subject to s. 628.34 (3), Stats., to withdraw the coverage back to the initial date of coverage, modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate

increase uniformly applied by the insurer to all similar individual policy forms is not a rescission or reformation of a policy.

SECTION 7. Ins 18.02 is repealed and recreated to read:

Ins 18.02 Applicability. (1) Notwithstanding any inconsistent provisions of s. 632.83 and 632.835, Stats., insurers offering group and individual health insurance coverage shall establish standards and procedures that, at a minimum, include consumer protections consistent with 45 CFR 147.136 (b), as amended, These standards apply to all of the following:

(a) Group and individual health insurance coverage.

(b) Grandfathered health plans that otherwise would be subject to section 2719 (a) of the Public Health Service Act (42 USC 300gg-19 (a)).

(c) A policy, certificate, or contract that provides only limited-scope dental or vision benefits.

(d) Coverage specified in s. 632.745 (11) (b) 10., Stats.

(2) Self-insured governmental health plans may elect to either comply with federal or state process for grievances and independent reviews.

SECTION 8. Ins 18.03 (1) (a) to (c), (2) (a), (b), (c) 1., 2. (intro.), c., and (d), (3) (intro.) (4), (5) (a) (intro.), (b) (intro.), (c) and (d), (6) (intro.), (b) (intro.), and (7) are amended to read:

Ins 18.03 (1) (a) Each insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall incorporate within its policies, certificates and outlines of coverage the definition of a grievance as stated in s. Ins ~~18.01 (4)~~ 18.015 (4).

(b) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall develop an internal grievance and expedited grievance procedure that includes a process for urgent care claims, that shall be described in each policy and certificate issued to insureds at the time of enrollment or issuance.

(c) In accordance with s. 632.83 (2) (a), Stats., an insurer that offers ~~a health benefit plans~~group or individual health insurance coverage shall investigate each grievance.

(2) (a) In addition to the requirements under sub. (1), each time an insurer offering ~~a health benefit plans~~group or individual health insurance coverage denies a claim or benefit or initiates disenrollment proceedings, the ~~health benefit plan~~insurer shall provide written ~~notify~~notification to the affected insured of the right to file a grievance. For purposes of this subchapter, denial or refusal of an insured's request of the insurer for a referral shall be considered a denial of a claim or benefit. The notice shall contain similar content as 45 CFR 147.136 (b) (2) E. and (3) E., as amended.

(b) When notifying the insured of their right to grieve the denial, determination, or initiation of disenrollment, an insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall ~~either~~ direct the insured to the policy or certificate section that delineates the procedure for filing a grievance ~~or shall describe, in detail, the grievance procedures to the insured~~. The notification shall also state the specific reason for the denial, determination or initiation of disenrollment.

(c) 1. An insurer offering ~~a health benefit plans~~group or individual health insurance coverage that is a defined network plan as defined in s. 609.01 (1b), Stats., other than a preferred provider plan as defined in s. 609.01 (4), Stats., shall do all of the following:

2. An insurer offering a ~~health benefit plan~~group or individual health insurance coverage that is a preferred provider plan as defined in s. 609.01 (4), Stats., shall do all of the following:

c. Include in its description of the grievance process required under sub. (1), a clear statement that an insured may submit to the insurer offering ~~a health benefit plan~~group or individual health insurance coverage a complaint or grievance relating to covered services provided by a participating health care provider.

(d) If the insurer offering a ~~health benefit plan~~group or individual health insurance coverage is either a health maintenance organization as defined in s. 609.01 (2), Stats., or a limited service health organization as defined by s. 609.01 (3), Stats., and the insurer initiates disenrollment proceedings, the insurer shall additionally comply with s. Ins 9.39.

(3) The grievance procedure utilized by an insurer offering ~~a health benefit plans~~group or individual health insurance coverage that does not involve a coverage denial determination shall include all of the following:

(4) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance.

(5) (a) (intro.) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage may require a written expression of authorization for representation from a person acting as the insured's authorized representative unless any of the following applies:

(b) (intro.) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall process a grievance without requiring written authorization unless the insurer, in its acknowledgement to the person under sub. (4), clearly and prominently does all of the following:

(c) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall accept under par. (a) any written expression of authorization without requiring specific form, language or format.

(d) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage group or individual health insurance coverage shall include in its acknowledgement of receipt of a grievance filed by an authorized representative a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law. The acknowledgement shall state that unless otherwise permitted under applicable law, including the Health Insurance Portability and Accountability Act of 1996, U.S. PL 104-191, ss. 51.30, 146.82 to 146.84, and 610.70, Stats., and ch. Ins 25, informed consent is required and the acknowledgement shall include an informed consent form for that purpose. An insurer offering ~~a health benefit plans~~group or individual health insurance coverage may withhold health care information or medical records from an authorized representative, including information contained in its resolution of the grievance, but only if disclosure is prohibited by law. An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall process a grievance submitted by an authorized representative regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

(6) An insurer offering ~~a health benefit plans~~group or individual health insurance coverage shall resolve a grievance:

(b) For any grievance not subject to par. (a), within 30 calendar days of receiving the grievance. If the insurer offering ~~a health benefit plans~~group or individual health insurance coverage is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days but only if the insurer provides a written notification to the insured and the insured's authorized representative, if applicable, of all of the following:

(7) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports including grievances involving coverage denial determinations, received by the commissioner from insurers offering ~~a health benefit plans~~group or individual health insurance coverage. The report shall also summarize OCI complaints involving the insurer offering ~~a health benefit plans~~group or individual health insurance coverage that were received by the office during the previous calendar year.

SECTION 9. Ins 18.035 and 18.0357 are created to read:

Ins 18.035 Coverage Denial Determination Grievances.

(1) DEFINITION AND EXPLANATION OF THE GRIEVANCE PROCEDURE INVOLVING COVERAGE DENIAL DETERMINATIONS. (a) Each insurer offering group or individual health insurance coverage shall incorporate within its policies, certificates and outlines of coverage the definition of an adverse determination and coverage denial determination as stated in s. Ins 18.015 (1) and (2m).

(b) An insurer offering group or individual health insurance coverage shall develop an internal grievance and expedited grievance procedures for coverage denial determinations that shall be described in each policy and certificate issued to insureds at the time of enrollment or issuance.

(c) In accordance with s. 632.83 (2) (a), Stats., an insurer that offers a health benefit plan shall investigate each grievance.

(2) NOTIFICATION OF RIGHT TO APPEAL COVERAGE DENIAL DETERMINATIONS. (a) In addition to the requirements under sub. (1) and s. 18.03, each time an insurer offering group or individual health insurance coverage makes a coverage denial determination the insurer shall notify the affected insured of the right to file a grievance. The notification shall include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount, if applicable. Within the notice the insurer shall include a statement that the insured or the insured's authorized representative may request the diagnostic code and its corresponding meaning, and the treatment code and its corresponding meaning. The diagnostic code and treatment code, if requested shall be provided as soon as practicable. An insured's or insured's authorized representative's request for the diagnostic or treatment code shall not be considered as a request for a grievance.

(b) When notifying the insured of their right to grieve the coverage denial determination, an insurer offering group or individual health insurance coverage shall state the specific reason for the determination and direct the insured to the policy or certificate section that delineates the procedure for filing a grievance involving coverage denial determinations.

(3) GRIEVANCE PROCEDURE INVOLVING A COVERAGE DENIAL DETERMINATION. The grievance procedure utilized by an insurer offering group or individual health insurance coverage involving coverage denial determinations shall include all of the following:

(a) A method whereby the insured who filed the grievance involving a coverage denial determination, or the insured's authorized representative has the right to appear in person before the grievance panel to present written or oral evidence and testimony. The insurer shall permit the grievant to review the claim file including, without charge, any new or additional evidence or rationale considered, relied upon, or generated by the insurer in connection with the claim. The new or additional evidence or rationale must be provided, without charge, as soon as possible and with sufficient advance notice to permit the insured or the insured's authorized representative time to respond before a final grievance determination is issued.

(b) A written notification to the insured of the time and place of the grievance meeting at least 7 calendar days before the meeting.

(c) Reasonable accommodations to allow the insured, or the insured's authorized representative, to participate in the meeting.

(d) The grievance panel shall comply with the requirements of s. 632.83 (3) (b), Stats., and shall not include the person who ultimately made the initial determination. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who ultimately made the initial determination. The panel may, however, consult with the ultimate initial decision-maker. In ensuring the independence and impartiality of individuals involved in making the coverage denial determination, the insurer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the coverage denial determination.

(e) The insured member of the panel shall not be an employee of the plan, to the extent possible.

(f) Consultation with a licensed health care provider with expertise in the field relating to the subject of the coverage denial determination grievance, if appropriate.

(g) The panel's written decision to the insured as described in s. 632.83 (3) (d), Stats., shall be signed by one voting member of the panel and include a written description of position titles of panel members involved in making the decision.

(4) RECEIPT OF GRIEVANCE ACKNOWLEDGMENT. An insurer offering group or individual health insurance coverage shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance.

(5) AUTHORIZATION FOR RELEASE OF INFORMATION. (a) An insurer offering a health benefit plan may require a written expression of authorization for representation from a person acting as the insured's authorized representative unless any of the following applies:

1. The person is authorized by law to act on behalf of the insured.

2. The insured is unable to give consent and the person is a spouse, family member or the treating provider.

3. The grievance is an expedited grievance and the person represents that the insured has verbally given authorization to represent the insured.

(b) An insurer offering group or individual health insurance coverage shall process a grievance involving a coverage denial determination without requiring written authorization unless the insurer, in its acknowledgement to the person under sub. (4), clearly and prominently does all of the following:

1. Notifies the person that, unless an exception under par. (a) applies, the grievance will not be processed until the insurer receives a written authorization.

2. Requests written authorization from the person.

3. Provides the person with a form the insured may use to give written authorization. An insured may, but is not required to, use the insurer's form to give written authorization.

(c) An insurer offering group or individual health insurance coverage shall accept under par. (a) any written expression of authorization without requiring specific form, language or format.

(d) An insurer offering group or individual health insurance coverage shall include in its acknowledgement of receipt of a grievance filed by an authorized representative a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law. The acknowledgement shall state that unless otherwise permitted under applicable law, including the Health Insurance Portability and Accountability Act of 1996, U.S. PL 104-191, ss. 51.30, 146.82 to 146.84, and 610.70, Stats., and ch. Ins 25, informed consent is required and the acknowledgement shall include an informed consent form for that purpose. The insurer may withhold health care information or medical records from an authorized representative, including information contained in its resolution of the grievance, but only if disclosure is prohibited by law. The insurer shall process a grievance submitted by an authorized

representative regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

(6) RESOLUTION OF A GRIEVANCE. An insurer offering group or individual health insurance coverage shall resolve a grievance:

(a) For a grievance that is a review of a benefit determination that is subject to 29 CFR 2560.503-1, within the time provided under 29 CFR 2560-503-1 (i).

(b) For any grievance not subject to par. (a), within 30 calendar days of receiving the grievance. If the insurer offering a health benefit plan is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days, if the insurer provides a written notification to the insured and the insured's authorized representative, if applicable, of all of the following:

1. That the insurer has not resolved the grievance.
2. When resolution of the grievance may be expected.
3. The reason additional time is needed.

(7) CONTINUED COVERAGE PENDING OUTCOME OF A GRIEVANCE. The insurer offering group or individual health insurance coverage shall provide continued coverage pending the outcome of the grievance in accordance with 45 CFR 147.136 (b) (2) (iii) and (3) (iii), as amended. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for appeal. Coverage must be continued regardless of whether the insurer intends to seek judicial review and until or unless there is a judicial decision.

18.0357 Urgent Care Benefit Determination. An insurer offering group or individual health insurance coverage shall establish procedures for receiving and processing a prior authorization or confirmation of coverage determination from an insured, or insured's authorized representative, for medical care or treatment involving an urgent care claim. A procedure shall comply with 45 CFR 147.16 (b) (2) (ii) (B) and (3) (ii) (B), as amended and comply with the following:

(a) If an insured fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the plan, the insurer shall notify the insured within 24 hours after receipt of the information necessary to complete claim and allow the insured at least 48 hours to provide the information to the insurer.

(b) The insurer shall notify the insured of the urgent care benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the insurer.

(c) The insurer shall comply with the requirements in s. 18.03, 18.035 and 18.11, as applicable.

SECTION 10. Ins 18.04, 18.05, 18.06 (intro.), (1), 18.10 (intro.), (1), (2) (intro.) (b), (c), (d), and (3) are amended to read:

Ins 18.04 The commissioner may require an insurer offering ~~a health benefit plan~~group or individual health insurance coverage to treat and process an OCI complaint as a grievance as appropriate, if the commissioner provides a written description of the complaint to the insurer. The insurer shall process the OCI complaint as a grievance in compliance with s. Ins 18.03 and 18.035.

Ins 18.05 (1) ~~Section~~Sections Ins 18.03 (2) to (4) and (6) and 18.035 (2) to (4) and (6) ~~does~~ do not apply to expedited grievance. For these situations, ~~a health benefit plan~~an insurer offering group or individual health insurance coverage shall develop a separate expedited grievance procedure. An expedited grievance shall be resolved as expeditiously as the insured's health condition requires but not more than 72 hours after receipt of the grievance request.

(2) An insurer offering ~~a health benefit plan~~group or individual health insurance coverage, upon written request, shall mail or electronically mail a copy of the insured's complete policy to the insured or the insured's authorized representative as expeditiously as the grievance is handled.

Ins 18.06 (intro.) An insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall comply with all of the following requirements:

(1) Each record of each complaint and grievance submitted to the insurer shall be kept and retained for a period of at least ~~3~~6 years. These records shall be maintained at the insurer's home or principal office and shall be available for review during examinations by or on request of the commissioner or office.

SECTION 11. Ins 18.10 (1), (2) (d) and (3) are repealed.

SECTION 12. Ins 18.10 (intro.), (2) (intro.) (b) and (c) are amended to read:

Ins 18.10 (intro.) ~~In~~Notwithstanding any inconsistent provisions of s. 632.835, Stats., in addition to the definitions in s. 632.835 (1), Stats., and s. Ins 18.015, in this subchapter:

(2) "Experimental treatment determination" means a determination by or on behalf of an insurer ~~that issues a health benefit plan~~offering group or individual health insurance coverage to which all of the following apply:

(b) Based on the information provided, the treatment under par. (a) is determined to be experimental under the terms of the ~~health benefit~~ policy or plan.

(c) Based on the information provided, the insurer that issued the ~~health benefit plan~~group or individual health insurance coverage denied the treatment under par. (a) or payment for the treatment under par. (a).

SECTION 13. Ins 18.105 is repealed and recreated to read:

Ins 18.105 (1) Notwithstanding any inconsistent provisions of s. 632.83 or 632.835, Stats., insurers offering group or individual health insurance coverage shall establish standards and procedures giving notice to insureds of their right to and eligibility for independent review consistent with 45 CFR 147.136 (c) (2), as amended, for coverage denial determinations that are based on any of the following:

(a) The insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(b) The insurer's determination that a treatment is experimental.

(c) A preexisting condition exclusion denial determination.

(d) The insurer's determination to rescind or reform, for individual health insurance coverage, a policy.

(2) Insurers offering group or individual health insurance coverage shall establish standards and procedures that comply with 45 CFR 147.136 (c) (2), as amended. These standards apply to insurers offering any of the following:

(a) Group and individual health insurance coverage subject to section 2719 (b) of the Public Health Service Act (42 USC 300gg-19 (b)).

(b) Grandfathered health plans.

(c) Coverage specified in s. 632.745 (11) (b) 10., Stats.

(d) Coverage specified in s. 632.745 (11) (b) 11., Stats., including Medicare supplement or replacement policies, but excluding Medicare advantage plans.

SECTION 14. Ins 18.11 (1), (2) (intro.), (a) and (b), (3) (intro.), (a) to (d), and (4) (a) are amended to read:

Ins 18.11 (1) Each insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall establish procedures to ensure compliance with ~~this section~~ s. 18.105 and 45 CFR 147.136 (c) (2), as amended, notwithstanding inconsistent provisions of s. 632.835, Stats. Insurers shall include a notice of the right to independent review and provide a description of the independent review process in the policy or attached to the policy, certificate, membership booklet, outline of coverage or other document of coverage provided to participants.

(2) In addition to the requirements of s. 632.835 (2) (b) or (2) (bg), Stats., notwithstanding provisions inconsistent with section 2719 (b) of the Public Health Service Act (42 USC 300gg-19 (b) (1)), 45 CFR 147.136 (c) (2), as amended, and s. 18.035, each time an insurer offering ~~a health benefit plan~~group or individual health insurance coverage makes a coverage denial determination the insurer shall provide all of the following in the notice to the insureds:

(a) A notice to an insured of the right to request an independent review. The notice shall reference the independent review section of the insured's policy, certificate or plan document and ~~to be accompanied by~~provide the informational brochure developed by the office or in a form substantially similar, ~~describe~~describing the independent review process. The notice shall be sent when the insurer offering ~~a health benefit plan~~group or individual health insurance coverage makes a coverage denial determination. In addition, the notice shall contain all of the following information:

2. ~~For coverage denial determinations occurring after June 15, 2002, the~~The notice to an insured shall, notwithstanding inconsistent provisions, in accordance with s. 632.835 (2) (c), Stats., state that the insured, or the insured's authorized representative, must request independent review within 4 months from the date of the coverage denial determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

3. The notice shall state that~~ the insured, or the insured's authorized representative shall select the independent review organization from the list of certified independent review organizations, accompanying the notice, as complied by the commissioner and available from the insurer~~ upon written notification of the insured's or the insured's authorized representative's decision to seek an independent review, the insurer shall contact the office's website and website application will assign, on a random, impartial basis a certified independent review organization. The insured will be notified by the insurer of the assigned independent review organization within one business day of the assignment.

Note: The commissioner maintains a current listing, revised at least quarterly, of certified independent review organizations and posts the current list on the office website: http/oci.wi.gov. In addition, the office website contains an application for insurers to complete to request an assignment of an independent review organization on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process for an independent or expedited independent review.

4. The notice shall state that the insured's, or the insured's authorized representative's, request for an independent review must be made in writing ~~and contain the name of the selected independent review organization~~unless otherwise

excepted. The notice shall also state that the insured's, or the insured's authorized representative, written request be submitted to the insurer ~~and~~. The insurer must ~~contain~~provide the address and name of the person or position to whom the request for independent review is to be sent within the notice.

5. The notice shall include a statement that complies with 45 CFR 147.136 (c) (2) (xi), as amended, and notwithstanding inconsistent provisions, ~~references~~ s. 632.835 (3) (f), Stats., informing the insured that once the independent review organization makes a final coverage determination, the final coverage determination ~~may be~~is binding upon the insurer and insured except to the extent other remedies are available under state or federal law. ~~For preexisting condition exclusion and rescission denial determinations, the notice shall indicate that the independent review organization determination is not binding on the insured.~~

6. The notice shall include a statement consistent with 45 CFR 147.136 (c) (2) (iii), notwithstanding inconsistent provisions in ~~that references~~ s. 632.835 (2) (d), Stats., informing the insured, or the insured's authorized representative, that they need not exhaust the internal grievance procedure if ~~either~~any of the following conditions are met:

a. Both the insurer offering ~~a health benefit plan~~group or individual health insurance coverage and the insured, or the insured's authorized representative, agree that the appeal should proceed directly to independent review.

b. ~~The independent review organization determines that an expedited review is appropriate upon receiving a request from an insured or the insured's authorized representative that is simultaneously sent to the insurer offering a health benefit plan~~The insured, or the insured's authorized representative simultaneously requests an expedited grievance and expedited independent review.

(b) ~~1.~~ For preexisting condition exclusion denial and rescission determinations ~~that occur on or after January 1, 2010, but prior to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) (b), Stats., the notice to an insured shall state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 (8) 9b), Stats.,~~

~~2. For preexisting condition exclusion denial and rescission determinations~~ occurring ~~subsequent to the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under s. 632.835 98) (b), Stats.,~~on or after February 15, 2011, the notice to an insured shall comply with sub. (2) (a), state that the insured, or the insured's authorized representative, must request the independent review within 4 months from the date of the preexisting condition exclusion denial or rescission determination by the insurer or from the date of receipt of notice of the grievance panel decision, whichever is later.

(3) ~~In~~The independent review process shall not exceed 45-days from the date the request for independent review is received by the insurer in compliance with 45 CFR 147.136 (c) (2) (xii), as amended. Notwithstanding inconsistent provisions, in addition to the requirements set forth in s. 632.835 (3), Stats., the following procedures shall be followed:

(a) The insurer offering ~~a health benefit plan~~group or individual health insurance coverage, upon receipt of a request for independent review, shall ~~provide written notice of the request to the commissioner and independent review organization~~ within 2 days of receipt complete all the information on the commissioner's website in order to have an independent review organization selected ~~by the insured or the insured's authorized representative within 2 business days of receipt~~.

Note: The commissioner maintains a current listing, revised at least quarterly, of certified independent review organizations on the office website: http/oci.wi.gov. In addition, the office's website contains an application for insurers to request an assignment on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process, an independent review organization for an independent or expedited review.

(b) The insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall provide the information required in s. 632.835 (3) (b), Stats., the insurer shall provide any records that relate to the coverage denial determination to the independent review organization without requiring a written release from the insured in accordance with s. 610.70 (5) (f), Stats.

(bm) The insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall provide, upon written request from the ~~insurer~~insured or the insured's authorized representative, a complete copy of the insured's policy. The insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall respond to the written request within 3 business days of the request by mailing or electronically mailing the copy to the insured or the insured's authorized representative in the format requested.

(c) Information submitted to the independent review organization at the request of the independent review organization by either the insurer or the insured, or the insured's authorized representative, shall also be ~~promptly~~ provided to the other party to the review within one business day .

(d) Paragraphs (a) to (~~c~~cm) do not apply to situations where the independent review organization determines that the normal duration of the independent review process would jeopardize the life or health of the insured or the insured's

ability to regain maximum function. For these situations, the independent review organization shall develop a separate expedited review procedure for expedited situations which complies with 45 CFR 147.136 (c) (2) (xiii), as amended, notwithstanding inconsistent provisions in s. 632.835 (3) (g), Stats. An expedited review shall be conducted in accordance with 45 CFR 147.136 (c) (2), as amended and s. 632.835 (3) (g) 1. to 4., Stats., notwithstanding inconsistent provisions, and shall be resolved as expeditiously as the insured's health condition requires not to exceed 72 hours after receipt of the request for expedited review.

(4) (a) A dispute between an insured and an insurer regarding eligibility for independent review shall be considered a coverage denial determination and the insured may ~~seek~~request an independent review of the determination in accordance with this section.

SECTION 15. Ins 18.11 (1m), (2) (a) 1., 6. am. and c., and 7., and (3) (cm) are created to read:

Ins 18.11 (1m) (a) The insurer offering group or individual health insurance coverage shall develop a procedure for contacting the commissioner through the commissioner's website, to have an independent review organization assigned.

(b) The procedure shall include a process for receiving electronic notice from the office of the assigned independent review organization and notification to the insured or the insured's representative.

(c) The procedure shall address a process for handling expedited requests for independent review specifically addressing after normal business hour requests.

(d) The procedure shall address a process for contacting the office and insured when the insurer is notified by the independent review organization that the organization electronically selected by the office has a conflict of interest.

(2) (a) 1. The notice shall include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount, if applicable. Within the notice the insurer shall include a statement that the insured or the insured's authorized representative may request the diagnostic code and its corresponding meaning, and the treatment code and its corresponding meaning. The diagnostic code and treatment code, if requested shall be provided as soon as practicable. An insured's or insured's authorized representative's request for the diagnostic or treatment code shall not be considered as a request for a grievance.

6. am. The insurer offering group or individual health insurance coverage waives the exhaustion requirement for independent review.

c. An insured is deemed to have exhausted the grievance process as a result of the insurer failing to comply with the requirements of 45 CFR 147.136 (b) (2) or (3), as amended, and s. 18.035, unless the insurer demonstrates to the independent review organization that the violations were de minimis and not a part of a pattern or practice of violations by the insurer. Additionally, the notice shall include information that the insured may request a written explanation of the de minimis violation from the insurer and the insurer shall provide the explanation within 10 days from the request.

7. The notice shall include a brief explanation regarding the insured's continued right to resubmit or continue pursuing the grievance if an independent review organization, or court of competent jurisdiction determines that the insurer complied with the grievance process or that a de minimis violation exception applied. The notice to resubmit or continue shall be provided to the insured or insured's authorized representative within 10 days from the determination that a grievance did not meet the exception requirements is subd. 6. The notice shall also indicate that the timeframes indentified in s. 18.035 (6) will commence upon receipt of the notice for resubmission or continuance.

(3) (cm) The independent review organization shall give notice of the right to provide additional written information. The notice shall provide the insured at least 5 business days to submit any additional information. Any information provided by the insured or insurer in writing shall be provided to the other party within one business day. The independent review organization shall consider that additional information when conducting the review.

SECTION 16. Ins 18.12 (1) (b) 4. is repealed:

SECTION 17. Ins 18.12 (1) (intro.), (a) 1., (b) 1. and 2., (e) (intro.), 1., 3., and 4., and (f) to (j), (3) (a), 18.13 (1), 18.14 (1), 18.16 (1) and (2) (b), (c) and (i), and 18.18 (3) are amended to read:

Ins 18.12 (1) Independent review organizations shall have, and demonstrate compliance with, written policies and procedures governing all aspects of both the standard review and expedited review processes as described in 45 CFR 147.136 (c), as amended, notwithstanding inconsistent provisions of s. 632.835, Stats., including all of the following:

(a) 1. Tracks applicable state and federal independent review laws and regulations including time limitations for completion of both standard and expedited reviews.

(b) 1. Whether a conflict of interest exists. If a conflict exists, the independent review organization shall provide a written notification to the insurer, the commissioner and the insured, or the insured's authorized representative, within 3 business days stating that a conflict exists and declining to take the review, indicating that a different independent review organization will need to be ~~selected~~requested by the ~~insured, or the insured's authorized respresentative~~insurer from the commissioner.

2. The type of case for which review is sought. The independent review organization shall determine if the case relates to coverage denial determination or an administrative issue in a manner consistent with 45 CFR 147.136 (c) (2), as amended. If the independent review organization determines that the review is not related to a coverage denial determination, the independent review organization shall provide written notification to the commissioner, the insured, or the insured's authorized representative, and the insurer of its determination that the claim is not eligible for review within 2 business days.

(e) 1. The insured's medical records including consulting reports from appropriate health care professionals.

3. The terms of coverage under the insured's ~~health benefit plan~~group or individual health insurance coverage.

4. Information accumulated regarding the case prior to its referral to independent review, including the practice guidelines, clinical review criteria developed by the insurer and the rationale for prior review determinations.

(f) Procedures for consideration of pertinent information for cases referred to the independent review organization regarding experimental treatment determinations including all information required in par. (e)~~ and existing medical or scientific evidence regarding the proposed treatment with respect to effectiveness and efficacy~~. The independent review organization's procedures shall include a review of the insurer's representation that the service or treatment is experimental for a particular medical condition and the treatment or service is not explicitly an excluded benefit; and the insured's treating physician's certification that one of the following is applicable to the insured:

1. Standard health care services or treatments have not been effective in improving the condition of the insured.

2. Standard health care services or treatments are not medically appropriate for the insured.

3. There is no available standard health care service or treatment covered by the insurer that is more beneficial than the recommended or requested health care service or treatment.

(g) Policies and procedures to request and accept any additional information that may assist in rendering a determination. Information received by the independent review organization from the insured or attending provider shall be provided to the insurer offering ~~a health benefit plan~~group or individual health insurance coverage in order to provide the insurer with the opportunity to reverse its decision.

(h) Procedures to ensure that within 2 business days of rendering a determination, the independent review organization shall, in addition to the requirements of s. 632.835 (3) (f), Stats., notwithstanding provisions inconsistent with 45 CFR 147.136 (c) (2) (xii), as amended, send to the insurer offering ~~a health benefit plan~~group or individual health insurance coverage, the insured, or the insured's authorized representative a written notice of the determination that includes all of the following:

(i) 1. Procedures to ensure expedited reviews are conducted and completed in ~~accordance with~~ a timely manner consistent with 45 CFR 147.136 (c) (2) (xiii), as amended, notwithstanding inconsistent provision in s. 632.835 (3) (g), Stats.,~~ and take into account the insured's health condition. Upon completion of the review, the independent review organization shall provide its decision within one hour, or as expeditiously as practicable, to the insured, or the insured's authorized representative, and the insurer.~~ and comply with all of the following:

a. Expedited reviews are available when the coverage denial determination related to an admission, availability of care, continued stay, or health care service, including experimental service or treatment or for which the insured received emergency services, but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the insured or jeopardize the insured's ability to regain minimum function.

b. Expedited reviews are to be completed as expeditiously as possible but within no more than a total of 72 hours after the receipt of the request for expedited independent review.

c. Upon completion of the review, the independent review organization shall provide its decision within one hour, or as expeditiously as practicable, to the insured, or the insured's authorized representative, and the insurer. If the decision is conveyed to the insured and insurer orally by the independent review organization, then within 48 hours after the date of the notice of decision, the independent review organization shall provide the insured and insurer the written determination.

2. Independent review organization procedures for expedited review of experimental or investigational treatment shall be consistent with subd. 1.

(j) Procedures to ensure that the decision of the independent review organization is consistent with 45 CFR 147.136 (c) (2), as amended, notwithstanding inconsistent provisions of s. 632.835 (3m), Stats.

(3) (a) The independent review organization shall establish a toll-free telephone and electronic mail service to receive information on a 24-hour, 7-days per week, basis. The telephone and electronic service selected shall be capable of accepting, recording or providing appropriate instruction to incoming telephone callers or electronic mail users during other than normal business hours.

Ins 18.13 (1) For coverage denial determinations~~, other than experimental treatment determinations,~~ independent review organizations shall consider any of the following:

Ins 18.14 (1) In addition to meeting the requirements established s. 632.835 (4) (a), Stats., any independent review organization seeking approval to conduct independent reviews shall submit an application for approval on a form prescribed by the commissioner and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization is unbiased, is accredited by organization nationally recognized private accrediting organization, and satisfies s. Ins 18.12.

Ins 18.16 (1) An independent review organization shall maintain records on all independent review activity during each calendar year and submit a report to the commissioner, on a form prescribed by the commissioner, by March 1 of each year for the prior calendar year's experience. Records shall be maintained so that, at a minimum, they satisfy the reporting requirements to the commissioner and shall be retained for at least ~~3~~6 years.

(2) (b) The total number of requests for independent review declined and the reason for the declination, including whether the request was a qualified request or within the scope of the ~~health benefit plan~~group or individual health insurance coverage policy.

(c) The total number of requests for expedited independent review that the independent review organization declined to handle in an expedited timeframe, including whether the request was a qualified request or within the scope of the ~~health benefit plan~~group or individual health insurance coverage policy.

(i) The number of independent reviews that were terminated as the result of reconsideration by the insurer offering ~~health benefit plan~~group or individual health insurance coverage of its coverage denial determination after the receipt of additional information from the insured, the insured's authorized representative, or other appropriate sources.

Ins 18.18 (3) An insurer offering ~~a health benefit plan~~group or individual health insurance coverage shall pay the fee submitted by the independent review organization within 30 days of receipt of a written invoice or billing record from the independent review organization.

SECTION 18. These changes first apply to claims occurring on or after January 1, 2012.

This chapter may be enforced under ss. 601.41, 601.64, 601.65, 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 19. These emergency rule changes will take effect on November 16, 2011, as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2011.

_____

Theodore K. Nickel
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for Section Ins ch. 18 relating to grievance and independent review requirements and affecting small business

This rule change will have no significant effect on the private sector regulated by OCI.