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LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1024

Introduced by Bostar, 29.

Read first time January 05, 2024

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to the Health Carrier External Review Act; to amend section 44-1308, Reissue Revised Statutes of Nebraska; to change provisions relating to documents and information provided to an independent review organization; and to repeal the original section.

Be it enacted by the people of the State of Nebraska,

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Section 1. Section 44-1308, Reissue Revised Statutes of Nebraska, is amended to read:

44-1308 (1)(a) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 44-1305, a covered person or the covered person's authorized representative may file a request for an external review with the director.

(b) Within one business day after the date of receipt of a request for an external review pursuant to subdivision (1)(a) of this section, the director shall send a copy of the request to the health carrier.

(2) Within five business days following the date of receipt of the copy of the external review request from the director under subdivision (1)(b) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time that the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time that the health care service was provided;

(b) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 44-1307; and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under subsection (2) of section 44-1305.

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(3)(a) Within one business day after completion of the preliminary review, the health carrier shall notify the director and covered person and, if applicable, the covered person's authorized representative, in writing whether:

(i) The request is complete; and

(ii) The request is eligible for external review.

(b) If the request:

(i) Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the director in writing and include in the notice what information or materials are needed to make the request complete; or

(ii) Is not eligible for external review, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the director in writing and include in the notice the reasons for its ineligibility.

(c)(i) The director may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(ii) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the director.

(d)(i) The director may determine that a request is eligible for external review under subsection (2) of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(ii) In making a determination under subdivision (3)(d)(i) of this section, the director's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Health Carrier External Review Act.

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(4)(a) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, the director shall, within one business day after the date of receipt of the notice:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 44-1312 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(ii) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(b) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in the Utilization Review Act or the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act.

(c) The director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or his or her authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to but may accept and consider additional information submitted after five business days.

(5)(a) Within five business days after the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and

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any information considered in making the adverse determination or final adverse determination. Any documents or information solely related to cost shall not be provided.

(b) Except as provided in subdivision (5)(c) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision (5)(a) of this section shall not delay the conduct of the external review.

(c)(i) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision (5)(a) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(ii) Within one business day after making the decision under subdivision (5)(c)(i) of this section, the independent review organization shall notify the covered person and, if applicable, the covered person's authorized representative, the health carrier, and the director.

(6)(a) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (5) of this section and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision (4)(c) of this section.

(b) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision (4)(c) of this section, the assigned independent review organization shall forward the information to the health carrier within one business day.

(7)(a) Upon receipt of the information, if any, required to be forwarded pursuant to subdivision (6)(b) of this section, the health

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carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision (7)(a) of this section shall not delay or terminate the external review.

(c) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(d)(i) Within one business day after making the decision to reverse its adverse determination or final adverse determination as provided in subdivision (7)(c) of this section, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, the assigned independent review organization, and the director in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (7)(d)(i) of this section.

(8) In addition to the documents and information provided pursuant to subsection (5) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit

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plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(e) 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, or associations;

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

(g) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (8)(a) through (f) of this section to the extent that the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

(9)(a) Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the director.

(b) The independent review organization shall include in the notice sent pursuant to subdivision (9)(a) of this section:

(i) A general description of the reason for the request for external review;

(ii) The date that the independent review organization received the assignment from the director to conduct the external review;

(iii) The date that the external review was conducted;

(iv) The date of its decision;

(v) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(vi) The rationale for its decision; and

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(vii) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(c) Upon receipt of a notice of a decision pursuant to subdivision (9)(a) of this section reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(10) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection (4) of section 44-1313.

Sec. 2. Original section 44-1308, Reissue Revised Statutes of Nebraska, is repealed.