AM161
LB147
MMM-02/06/2013

AMENDMENTS TO LB 147

Introduced by Gloor

1. Insert the following new sections:

Sec. 19. Section 44-7306, Reissue Revised Statutes of Nebraska, is amended to read:

44-7306 (1) A health carrier shall maintain in a grievance register written records to document all grievances received during a calendar year. A request for a ~~first-level~~ review of an adverse determination shall be processed in compliance with section 44-7308 but not considered a grievance for purposes of the grievance register unless such request includes a written grievance. ~~A request for a second-level review of an adverse determination shall be considered a grievance for purposes of the grievance register.~~ For each grievance required to be recorded in the grievance register, the grievance register shall contain, at a minimum, the following information:

(a) A general description of the reason for the grievance;

(b) Date received;

(c) Date of each review or hearing;

(d) Resolution ~~at each level~~ of the grievance;

(e) Date of resolution; ~~at each level;~~ and

(f) Name of the covered person for whom the grievance was filed.

(2) The grievance register shall be maintained in a

manner that is reasonably clear and accessible to the director. A grievance register maintained by a health maintenance organization shall also be accessible to the Department of Health and Human Services.

(3) A health carrier shall retain the grievance register compiled for a calendar year for the longer of three years or until the director has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Sec. 20. Section 44-7308, Reissue Revised Statutes of Nebraska, is amended to read:

44-7308 (1) If a covered person makes a request to a health carrier for a health care service and the request is denied, the health carrier shall provide the covered person with an explanation of the reasons for the denial, a written notice of how to submit a grievance, and the telephone number to call for information and assistance. The health carrier, at the time of a determination not to certify an admission, a continued stay, or other health care service, shall inform the attending or ordering provider of the right to submit a grievance or a request for an expedited review and, upon request, shall explain the procedures established by the health carrier for initiating a review. A grievance involving an adverse determination may be submitted by the covered person, the covered person's representative, or a provider acting on behalf of a covered person, except that a provider may not submit a grievance involving an adverse determination on behalf of a covered person in a situation in which federal or other state law prohibits a provider

from taking that action. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise. A health carrier shall issue a copy of the written decision to a provider who submits a grievance on behalf of a covered person. A health carrier shall conduct a ~~first-level~~ review of a grievance involving an adverse determination in accordance with subsection (3) of this section and section 44-7310, but such a grievance is not subject to the grievance register reporting requirements of section 44-7306 unless it is a written grievance.

(2)(a) A grievance concerning any matter except an adverse determination may be submitted by a covered person or a covered person's representative. A health carrier shall issue a written decision to the covered person or the covered person's representative within fifteen working days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If the health carrier cannot make a decision within fifteen working days due to circumstances beyond the health carrier's control, the health carrier may take up to an additional fifteen working days to issue a written decision, if the health carrier provides written notice to the covered person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

(b) A covered person does not have the right to attend, or to have a representative in attendance, at the ~~first-level~~

grievance review. A covered person is entitled to submit written material. The health carrier shall provide the covered person the name, address, and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within three working days after receiving a grievance.

(3) The written decision issued pursuant to the procedures described in subsections (1) and (2) of this section and section 44-7310 shall contain:

(a) The names, titles, and qualifying credentials of the person or persons acting as the reviewer or reviewers participating in the ~~first-level~~ grievance review process;

(b) A statement of the reviewers' understanding of the covered person's grievance;

(c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(d) A reference to the evidence or documentation used as the basis for the decision;

(e) In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

~~(f) If applicable, a statement indicating:~~

~~(i) A description of the process to obtain a second-level grievance review of a decision; and~~

~~(ii) The written procedures governing a second-level~~

~~review, including any required timeframe for review; and~~

(g) Notice of the covered person's right to contact the director's office. The notice shall contain the telephone number and address of the director's office.

Sec. 21. Section 44-7310, Reissue Revised Statutes of Nebraska, is amended to read:

44-7310 (1) A health carrier shall establish written procedures for a standard review of an adverse determination. Review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) When reasonably necessary or when requested by the provider acting on behalf of a covered person, standard reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination.

(3) For standard reviews the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within fifteen working days after the request for a review. The written decision shall contain the provisions required in subsection (3) of section 44-7308.

(4) In any case in which the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the

covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. ~~A health carrier that offers managed care plans shall review it as a second-level grievance.~~

Sec. 22. Section 44-7311, Reissue Revised Statutes of Nebraska, is amended to read:

44-7311 (1) A health carrier shall establish written procedures for the expedited review of a grievance involving a situation in which the timeframe of the standard grievance procedures set forth in sections 44-7308 to 44-7310 would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. A request for an expedited review of an adverse determination may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. However, for purposes of the grievance register requirements of section 44-7306, a request for an expedited review shall not be included in the grievance register unless the request is submitted in writing. Expedited review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) Expedited reviews which result in an adverse determination shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage

the case being reviewed. The clinical peer or peers shall not have been involved in the initial adverse determination.

(3) A health carrier shall provide expedited review to all requests concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

(4) An expedited review may be initiated by a covered person or a provider acting on behalf of a covered person.

(5) In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of a covered person by telephone, facsimile, or the most expeditious method available.

(6) In an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the review is commenced. If the expedited review is a concurrent review determination, the health care service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(7) A health carrier shall provide written confirmation of its decision concerning an expedited review within two working days after providing notification of that decision, if the initial notification was not in writing. The written decision shall contain the provisions required in subsection (3) of section 44-7308.

(8) A health carrier shall provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

(9) In any case in which the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. ~~A health carrier that offers managed care plans shall review it as a second-level grievance.~~ Except as expressly provided in this section, in conducting the review, the health carrier shall adhere to timeframes that are reasonable under the circumstances.

(10) A health carrier shall not be required to provide an expedited review for retrospective adverse determinations.

Sec. 23. Original sections 44-7306, 44-7308, 44-7310, and 44-7311, Reissue Revised Statutes of Nebraska, are repealed.

2. On page 5, line 3, strike "and" and insert "if"; and in line 5, strike the commas and after "functions" insert "or".

3. On page 7, line 18, strike "its" and insert "their".

4. On page 9, line 18, after "after" insert "health care".

5. On page 10, line 22; and page 22, line 16, strike the comma.

6. On page 46, line 22, strike "evidenced" and insert "evidence".

AM161
LB147
MMM-02/06/2013

7. On page 47, line 25, strike "(10)(a)" and insert "(10)(c)".

8. On page 48, line 1, strike "(iii)".

9. On page 52, line 19, strike "this" and insert "the".

10. On page 55, line 10, after "independent" insert "review".

11. On page 57, line 23, strike the first "an".

12. On page 60, line 6, strike "(3)" and insert "(d)".

13. Renumber the remaining section accordingly.