MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Representative Baker (74th)

To: Public Health and Human Services; Insurance

HOUSE BILL NO. 1214

AN ACT TO PROVIDE FOR THE APPEAL OF ADVERSE DETERMINATIONS BY UTILIZATION REVIEW ENTITIES, HEALTH INSURERS OR MANAGED CARE ORGANIZATIONS NOT TO CERTIFY CERTAIN MEDICAL TREATMENTS OR SERVICES, BASED ON DETERMINATIONS THAT SUCH SERVICES OR TREATMENT ARE NOT MEDICALLY NECESSARY OR APPROPRIATE; TO PROVIDE THAT SUCH APPEALS MAY BE MADE TO THE COMMISSIONER OF INSURANCE; TO DEFINE CERTAIN TERMS; TO PROVIDE THAT THE COMMISSIONER OF INSURANCE SHALL ENGAGE IMPARTIAL HEALTH ENTITIES TO REVIEW SUCH APPEALS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following words and phrases have the meanings ascribed in this section unless the context clearly indicates otherwise:

(a) "Adverse determination" means a determination by a utilization review entity, health insurer or managed care organization not to certify an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review entity, health insurer or managed care organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

(b) "Business day" means a day during which the governmental agencies of the State of Mississippi conducts regular business.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Department" means the Department of Insurance.

(e) "Enrollee" means a person who has contracted for or who participates in a managed care plan or health insurance plan for himself or his eligible dependents who participate in a managed care plan or his authorized representative.

(f) "Health insurer" means any entity authorized in this state to write health insurance or that provides health insurance in this state and is subject to the state insurance laws.

(g) "Indigent individual" means an individual whose adjusted gross income for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent (200%) of the applicable federal poverty level.

(h) "Internal mechanism" means the procedures provided by a utilization review entity, health insurer or managed care organization in which either an enrollee, or provider acting on behalf of an enrollee, may seek review of decisions not to certify an admission, procedure, service or extension of stay.

(i) "Provider" means a physician, optometrist, chiropractor, dentist, podiatrist, psychologist or hospital licensed by the State of Mississippi.

(j) "Utilization review entity" means an entity performing utilization review. However, the following are not utilization review entities:

(i) An agency of the federal government;

(ii) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;

(iii) An agency of the State of Mississippi, or

(iv) A hospital's internal quality assurance program.

(k) "Utilization review" means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients as to necessity for the purpose of determining whether such service should be covered or provided by a managed care organization or health insurer.

SECTION 2. (1) An enrollee, or a provider acting on behalf of an enrollee with the enrollee's consent, may appeal an adverse determination if the enrollee or provider, as applicable, has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review entity to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service or procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service procedure or extension of stay.

(2) (a) To appeal a denial or determination under this section, an enrollee or any provider acting on behalf of an enrollee shall file, not later than thirty (30) days after receiving final written notice of the denial or determination from the enrollee's managed care organization, health insurer or utilization review entity, a written request with the commissioner. The appeal must be on forms prescribed by the commissioner including a release executed by the enrollee for all medical records pertinent to the appeal and must include the filing fee set forth in paragraph (b) of this subsection. The managed care organization, health insurer or utilization review entity named in the appeal also must pay to the commissioner the filing fee set forth in paragraph (b) of this subsection. If the commissioner receives three (3) or more appeals of denials or determinations by the same managed care organization, health insurer or utilization review entity with respect to the same procedural or diagnostic coding, the commissioner, in his discretion, may issue an order specifying how such managed care organization, health insurer or utilization review entity shall make determinations about such procedural or diagnostic coding.

(b) The filing fee is Twenty-five Dollars ($25.00). However, such fee shall be waived for an enrollee who is receiving social security disability benefits or similar public benefits.

In addition, if the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner must waive the enrollee's fee. The commissioner shall refund any paid filing fee to: the party paying the fee if the appeal is not accepted for full review, or to the prevailing party upon completion of a full review under this section.

(c) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity described under subsection (3) of this section.

(d) Upon receipt of the request for an appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if the entity determines: (i) the individual was or is an enrollee of the managed care organization or health insurer; (ii) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (iii) the enrollee has exhausted all internal mechanisms provided; and (iv) the enrollee has provided all information required by the commissioner to make a preliminary determination, including the appeal form, a copy of the final decision of denial and a fully executed release to obtain any necessary medical records from the managed care organization or health insurer, and any other relevant provider.

(e) Upon completion of the preliminary review, the entity conducting such review shall immediately notify the enrollee or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

(f) If accepted for full review, the entity shall conduct the review in accordance with the regulations adopted by the commissioner, after consultation with the State Health Officer.

(3) To provide for an appeal, the commissioner, after consultation with the State Health Officer, shall engage impartial health entities to provide for medical review under this section. The review entities must include: medical peer review organizations; independent utilization review entities, provided such entities or companies are not related to or associated with any managed care organization or health insurer; and nationally recognized health experts or institutions approved by the commissioner.

(4) (a) Not later than five (5) business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's managed care plan or health insurer is fully insured, self-funded or otherwise funded. If the plan is a fully insured plan, the managed care organization or health insurer shall send: (i) written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (ii) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer; or (iii) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy.

(b) Failure of the managed care organization or health insurer to provide information in accordance with paragraph (a) of this subsection within the period of five (5) business days or before the expiration of the thirty-day period for appeals prescribed in subsection (2)(a) of this section, whichever is later as determined by the commissioner, creates a presumption on

the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subsection (2)(d) of this section, that the benefit or service is a covered benefit under the applicable policy or contract; however, the presumption may not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract. Further, such failure entitles the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing an adverse determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

(5) The commissioner must accept the decision of the review entity, and the decision of the commissioner is binding.

(6) Not later than January 1, 2008, the commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program must maximize public information concerning the appeals procedure and must include, but is not limited to: (a) the dissemination of information through mass media, interactive approaches and written materials; (b) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (c) periodic evaluations of the effectiveness of educational efforts.

SECTION 3. This act shall take effect and be in force from and after July 1, 2007.