ORIGINAL SENATE **ENGROSSED**
FILE NO. 0095

ENROLLED ACT NO. 35, SENATE

SIXTIETH LEGISLATURE OF THE STATE OF WYOMING
2009 GENERAL SESSION

AN ACT relating to insurance; defining medical necessity; setting requirements for analyzing insurance coverage and benefit payments under a medical necessity standard; setting requirements for denying payment or coverage; establishing review procedures; modifying unfair claims settlement practices accordingly; allocating costs; and providing for effective dates.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-40-201 is created to read:

ARTICLE 2
MEDICAL NECESSITY STANDARD

26-40-201. Payment of claims under medical necessity standard; review.

(a) As used in this section, "medical necessity or other similar basis" includes, but is not limited to, "medically necessary," "medically necessary care" and "medically necessary and appropriate," as defined in W.S. 26-40-102(a)(iii).

(b) If any disability insurance policy, as defined by W.S. 26-5-103, provides for settlement of a claim for payment of medical services, procedures or supplies provided by a health care provider using a medical necessity or other similar basis the insurer shall:

(i) Define medical necessity or other similar basis as "medical necessity" is defined in this chapter and W.S. 26-40-102(a)(iii);

(ii) Make all determinations whether a medical service, procedure or supply is medically necessary based only upon the factors stated in the definition of medical necessity contained in W.S. 26-40-102(a)(iii);

(iii) Provide internal review and external review procedures for all denied claims as required in this section and disclose all procedures, time lines and requirements for such review procedures in every disability insurance policy and as otherwise required in this section.

(c) When any claim for the provision of or payment for medical services, procedures or supplies is first denied as not being a medical necessity, or on another similar basis, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the settlement and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(i) A statement in the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by following the procedures outlined in this notice. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you."; and

(ii) A statement describing a procedure for having the claim denial reviewed by the insurer, including all applicable time limits, requirements and a process for having a expedited review initiated as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

(A) The timeframe for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(B) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(d) A claimant shall have not less than thirty (30) days in which to file a request for the review provided in subsection (c) of this section and such review shall be completed by the insurer, and a decision delivered to the claimant, no later than forty-five (45) days after receipt of a request for review.

(e) If a claim for the provision of or payment for medical services, procedures or supplies is denied on the basis that it is not a medical necessity, or on other similar basis, after having been reviewed by the insurer pursuant to subsection (c) or (d) of this section, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the decision and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(A) The signed opinion of at least one (1) credited medical consultant who agrees with the denial and who is not an employee of the insurer if requested by the claimant;

(B) A statement in the following, or substantially equivalent, language: "We have denied your

request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us and is not the attending physician or the physician's partner by following the procedures outlined in this notice. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you."; and

(C) A statement describing the procedure for having the denied claim reviewed by an external review organization pursuant to regulations adopted by the commissioner. The statement shall include a description of all procedures, time limits and requirements, including those related to expedited reviews, which the claimant must follow to obtain an external review and include a request for external review form and release of records form approved by the commissioner.

(f) Within sixty (60) days of receiving the written explanation required by subsection (e) of this section, a claimant may request an external review of the decision which is the subject of the explanation by filing a written request for such review. The request shall be submitted to the insurer on a form approved by the commissioner, unless such form was not provided to the claimant as required by subsection (e) of this section, in which event any written request for an external review shall be sufficient.

(g) Upon receiving a request for external review, the insurer shall:

(i) Immediately send a copy of the request to the commissioner;

(ii) Assign the request to an independent review organization that has been approved by the commissioner for a preliminary review. The insurer shall provide to the independent review organization all documents and information upon which the insurer relied in denying all claims under review. Failure to provide the documents and other information shall not delay the conduct of the external review. The independent review organization shall determine whether:

(A) The claimant is or was a covered person in the disability insurance policy at the time the provision of or payment for medical services, procedures or supplies was requested or provided;

(B) The provision of or payment for medical services, procedures or supplies requested by the claimant reasonably appears to be a covered service under the disability insurance policy, but for the determination by the insurer that the services, procedures or supplies are not a medical necessity;

(C) The insurer has denied the claimant's request for the provision of or payment for medical services, procedures or supplies after having been given the opportunity to review the insurer's first denial one (1) or more times;

(D) The claimant has provided to the insurer all the information and forms required to process an external review, including a release form, approved by the commissioner, by which the claimant authorizes the release of protected health information pertinent to the external review.

(h) The independent review organization shall within five (5) days determine whether the documentation is complete and immediately notify the claimant and the insurer in writing whether the documentation is complete and, if not, what information or documentation is missing. The claimant may submit in writing to the independent review organization any additional supporting documentation that the independent review organization should consider or may require when conducting its external review. If the request for review is not complete, the independent review organization shall require from the insurer or the claimant the information or materials needed to make the request complete.

(j) All documentation or other information provided to the independent review organization by the insurer or claimant shall also be immediately provided to the adverse party by the independent review organization. The insurer may use any documentation or other information provided by the claimant to reconsider its settlement of the claims. If the insurer chooses to reverse its prior decision, it shall immediately provide written notice to the claimant, the independent review organization and the commissioner, at which time the review shall be terminated.

(k) In addition to the documents and information provided pursuant to this section, the independent review organization, to the extent the information is available and the independent review organization considers them appropriate, shall consider the following in reaching its decision:

(i) The claimant's medical records;

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

(iii) Consulting reports from appropriate health care professionals and other documents submitted by the insurer, claimant or the claimant's treating provider;

(iv) The terms of coverage under the claimant's disability insurance policy;

(v) The standards identified in W.S. 26-40-102(a)(iii);

(vi) All evidence based research used in the insurer's denial of the claim.

(m) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice to the claimant, the insurer and the commissioner of its decision to uphold or reverse the decision of the insurer that the provision of or payment for medical services, procedures or supplies requested by the claimant are not medically necessary. Such written notice shall include:

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

(ii) The date the independent review organization received the assignment from the insurer to conduct the review;

(iii) The date the external review was conducted;

(iv) The date of its decision;

(v) The principal reasons for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or documentation considered in reaching its decision.

(n) In the event the external review organization determines the claims should be allowed, the insurer shall approve the request for the provision of or payment for medical services, procedures or supplies that was the subject of the review and notify the claimant of such approval within five (5) days.

(o) The engagement by an insurer of an independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The insurer, insured and the independent review organization shall comply with regulations promulgated by the commissioner to ensure fairness and impartiality in the engagement of approved independent review organizations, in the terms, termination and payment of independent review organizations and in the review process.

(p) The commissioner shall adopt regulations establishing an expedited review by an external review organization as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, and which allows an expedited external review where:

(i) The timeframe for the completion of a normal external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(ii) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(q) The insurer against whom a request for external review is filed shall pay the costs of the independent review organization's external review.

(r) The commissioner shall adopt such regulations as are necessary to promote the purposes of this section, which regulations shall include:

(i) Fees, including the waiver of fees for indigent persons;

(ii) Standards and procedures for the approval of independent review organizations;

(iii) External review organization reporting and record retention requirements.

(s) An insurer required to comply with the notification and appeal procedures of the Employee Retirement Income Security Act, and being compliant therewith, shall be deemed in compliance with this section.

Section 2. W.S. 26-13-124(a)(xiii) and by creating new paragraphs (xv) through (xvii) and 26-40-102(a) by creating a new paragraph (iii) are amended to read:

26-13-124. Unfair claims settlement practices.

(a) A person is considered to be engaging in an unfair method of competition and unfair and deceptive act or practice in the business of insurance if that person commits or performs with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; ~~or~~

(xv) Denying or failing to timely pay disability insurance claims for medically necessary services, procedures or supplies as required by W.S. 26-40-201;

(xvi) Failing to comply with the external review procedures required by W.S. 26-40-201; or

(xvii) Failing to pay a claim after an external review organization has declared such claim to be a benefit covered under the terms of the insurance policy.

26-40-102. Definitions.

(a) As used in this chapter:

(iii) "Medical necessity," means:

(A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

(I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;

(II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;

(III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and

(IV) Is not primarily for the convenience of the patient, physician or other health care provider.

(B) A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

(I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

(II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

Section 3. This act applies to disability insurance policies and certificates of coverage issued, renewed, delivered or issued for delivery in this state on or after July 1, 2010.

Section 4. The insurance commissioner may adopt rules and regulations implementing the provisions of this act upon the effective date of this section.

Section 5.

(a) Section 4 of this act is effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, section 8 of the Wyoming Constitution.

ORIGINAL SENATE
FILE NO. 0095

ENROLLED ACT NO. 35, SENATE

SIXTIETH LEGISLATURE OF THE STATE OF WYOMING
2009 GENERAL SESSION

(b) Except as provided in subsection (a) of this section, this act is effective July 1, 2010.

(END)

Speaker of the House

President of the Senate

Governor

TIME APPROVED: _____
DATE APPROVED: _____

I hereby certify that this act originated in the Senate.

Chief Clerk