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106TH CONGRESS
1ST SESSION

H. R. 2309

To require group health plans and health insurance issuers to provide independent review of adverse coverage determinations.

IN THE HOUSE OF REPRESENTATIVES

JUNE 22, 1999

Mr. SESSIONS introduced the following bill; which was referred to the Committee on Education and the Workforce

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A BILL

To require group health plans and health insurance issuers to provide independent review of adverse coverage determinations.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Independent Medical Review Act of 1999''.

SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsections:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) IN GENERAL.—The claims procedures required by this section shall include—

''(A) notification to a participant or beneficiary of the participant or beneficiary's right to appeal an adverse determination to a utilization review agent;

''(B) notification to a participant or beneficiary of the participant or beneficiary's right to appeal an adverse determination of a utilization review agent to an independent review organization;

''(C) notification to a participant or beneficiary of the procedures for appealing an adverse determination to an independent review organization;

''(D) notification to a participant or beneficiary who has a life-threatening condition of the participant or beneficiary's right to immediate review by an independent review organiza-

tion and the procedures to obtain such review; and

''(E) procedures for a fair, de novo determination of medical necessity by the independent review organization without regard to the definition used by the plan.

''(c) APPEAL OF ADVERSE DETERMINATION.—In a case in which an employee benefit plan denies a claim for benefits under the plan to a participant or beneficiary, such participant or beneficiary may appeal such adverse determination to a utilization review agent. The procedures for appeals shall be reasonable and shall include the following:

''(1) A provision indicating that a participant or beneficiary, a person acting on behalf of the participant or beneficiary, or the participant or beneficiary's physician or health care provider may appeal the adverse determination orally or in writing.

''(2) A provision that the utilization review agent shall send to the appealing party, within 5 working days after receipt of a written appeal, a letter acknowledging the date of the utilization review agent's receipt of the appeal and including a reasonable list of documents needed to be submitted by the

appealing party to the utilization review agent for the appeal.

''(3) In a case in which a utilization review agent receives an oral appeal of adverse determination, the utilization review agent shall send a one page appeal form to the appealing party.

''(4) A provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination, and such specialty review shall be completed within 15 working days of receipt of the request.

''(5) A method for an expedited appeal procedure for emergency care denials, denials of care for life threatening conditions, and denials of continued stays for hospitalized patients. Such procedure shall include a review by a health care provider who has not previously reviewed the case who is of the same or a similar specialty as typically manages the med-

ical condition, procedure, or treatment under review. The time frame in which such appeal must be completed shall be based on the medical or dental immediacy of the condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received.

''(6) A provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent shall issue a response letter to the patient, person acting on behalf of the patient, or the patient's physician or health care provider explaining the resolution of the appeal. Such letter shall include a statement of the specific medical, dental, or contractual reasons for the resolution, the clinical basis for such decision, and the specialization of any physician or other provider consulted.

''(7) Written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than 30 days after the date of the utilization review agent receives the appeal.

''(d) INDEPENDENT REVIEW OF ADVERSE DETERMINATIONS.—

''(1) IN GENERAL.—In a case in which an appeal of an adverse determination is denied by a utilization review agent, a participant or beneficiary may seek review of such adverse determination from an independent review organization.

''(2) ELEMENTS OF INDEPENDENT REVIEW PROCESS.—

''(A) IN GENERAL.—The independent review process under this subsection shall be conducted by an independent review organization and shall ensure—

''(i) a timely response by the independent review organization;

''(ii) confidentiality of medical records transmitted for use in the review process;

''(iii) the independence of each health care provider or physician making review determinations as part of an independent review organization; and

''(iv) timely notice to the participant or beneficiary of the results of the independent review, including the clinical basis for the determination.

''(B) INFORMATION PROVIDED TO THE INDEPENDENT REVIEW ORGANIZATION.—Not

later than 3 business days after the date that an independent review organization receives a request for a review of an adverse determination of a utilization review agent, such utilization review agent shall provide to the appropriate independent review organization—

''(i) any medical records of the participant or beneficiary that are relevant to the review;

''(ii) any documents used by the utilization review agent in making the determination that is to be reviewed by the organization;

''(iii) written notification to the participant or beneficiary indicating the clinical basis for the denial of the appeal;

''(iv) any documentation and written information submitted to the utilization review agent in support of the appeal; and

''(v) a list of each physician or health care provider who has provided care to the participant or beneficiary and who may have medical records relevant to the appeal.

"(C) TIMELINES FOR DETERMINATIONS BY INDEPENDENT REVIEW ORGANIZATION.—

"(i) IN GENERAL.—An independent review organization shall make its determination not later than the earlier of—

"(I) the 15th day after the date the independent review organization receives the information necessary to make the determination; or

"(II) the 20th day after the date the independent review organization receives the request that the determination be made.

"(ii) LIFE-THREATENING CONDITION.—In the case of a life-threatening condition, an independent review organization shall make its determination not later than the earlier of—

"(I) the 5th day after the date the independent review organization receives the information necessary to make the determination; or

"(II) the 8th day after the date the independent review organization

receives the request that the determination be made.

"(3) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS.—

"(A) IN GENERAL.—To be treated as an independent review organization, an organization must be certified by the Secretary.

"(B) APPLICATION FOR CERTIFICATION.—To be certified by the Secretary as an independent review organization, an organization shall submit on an annual basis to the Secretary an application which shall include the following information:

"(i) Any applicant that is a publicly held organization shall include the name of each stockholder or owner of more than 5 percent of any stock or options.

"(ii) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control.

"(iii) The name of any holder of bonds or notes of the applicant that exceed $100,000.

''(iv) The name and a biographical sketch of each director, officer, and executive of the applicant.

''(v) A description of any relationship the individuals in clauses (iii) and (iv) have with—

''(I) a provider of health insurance coverage;

''(II) a health maintenance organization;

''(III) a utilization review agent;

''(IV) a nonprofit health corporation;

''(V) a payor;

''(VI) a health care provider; or

''(VII) a group representing any of the entities described in subclauses (I) through (VII).

''(vi) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under this subsection.

''(vii) A description of the areas of expertise of the health care professionals

making review determinations for the applicant.

''(viii) The procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under this section.

''(4) INDEPENDENT REVIEW DETERMINATION BINDING ON PLAN.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination by an independent review organization under this subsection shall be treated as the final decision of the plan.

''(B) VACATION OR MODIFICATION OF DECISION.—The determination by an independent review entity under this section may be vacated or modified by a court under the same circumstances as the decision of an arbitrator may be vacated or modified under sections 10 and 11 of title 9, United States Code.

''(5) INDEPENDENCE REQUIREMENT.—An independent review organization may not be a subsidiary of, or in any way owned or controlled by a payor or a trade or professional association of a payor.

''(6) WAIVER OF LIABILITY.—An independent review organization conducting a review under this

section is not liable for damages arising from the determination made by the organization.

''(e) DEFINITIONS.—For purposes of this section:

''(1) ADVERSE DETERMINATION.—The term 'adverse determination' means determination by a group health plan or a utilization review agent that the health care services furnished or proposed to be furnished to a participant or beneficiary are not medically necessary.

''(2) HEALTH CARE PROVIDER.—The term 'health care provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(3) LIFE-THREATENING CONDITION.—The term 'life-threatening condition' means a disease or other medical condition with respect to which death

or serious bodily injury is probable unless the course of the disease or condition is interrupted.

''(4) PAYOR.—The term 'payor' means—

''(A) an insurer writing health insurance policies;

''(B) any preferred provider organization, or health maintenance organization, self-insurance plan; or

''(C) any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to an individual treated by a health care provider.

''(5) UTILIZATION REVIEW AGENT.—The term 'utilization review agent' means an entity that conducts utilization review for—

''(A) an employer with employees who are covered under a group health plan;

''(B) a payor; or

''(C) an administrator.

''(6) WORKING DAY.—The term 'working day' means a weekday, excluding any legal holiday.''.

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