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General Agency, Board or Commission Rules

Chapter 63: Medical Necessity Review Rights

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Chapter 63

Medical Necessity Review Rights

Section 1. Authority

(a) This regulation is promulgated pursuant to W.S. §§ 26-40-201 and 26-2-110 of the Wyoming Insurance Code and pursuant to the Wyoming Administrative Procedures Act, W.S. § 16-3-101, *et seq*.

Section 2. Purpose and Intent

(a) The purpose of this Rule is to provide uniform standards for giving notice to claimants of their right to an independent review of any denial of an insurance claim as not medically necessary or on a similar basis, and to establish internal and external review procedures to assure that claimants under any insurance policy have the opportunity for an independent review in accordance with W. S. § 26-40-201.

Section 3. Definitions

(a) For purposes of this Rule:

(b) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(c) "Authorized representative" means:

(i) A person to whom a claimant has given express written consent to represent the claimant in an external review;

(ii) A person authorized by law to provide substituted consent for a claimant; or

(iii) A family member of the claimant or the claimant's treating health care professional only when the claimant is unable to provide consent.

(d) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(e) "Certification" means a determination by an insurer or its designee utilization review organization, or the claimant's treating health care professional that medical service has been reviewed and, based on the information provided, satisfies the statutory requirements for medical necessity as defined by W.S. § 26-40-102.

(f) "Claimant" means a policyholder, subscriber, enrollee or other individual participating in an insurance policy.

(g) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an insurer to determine the necessity and appropriateness of health care services.

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

(i) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(j) "Denial of claim" means a determination by an insurer or its designee utilization review organization that a medical service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity or other similar basis, and the requested service or payment for the service is therefore denied, reduced or terminated..

(k) "Insurance carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that transacts the business of insurance as defined by W.S. §26-1-102(a)(xv).

(l) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(m) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(n) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(o) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(p) "Facility" means an institution providing medical services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(q) "Insurance policy" means any contract, certificate, agreement, clauses, riders, and endorsements, offered or issued by an insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(r) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(s) "Health care provider" or "provider" means a health care professional or a facility.

(t) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(i) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(ii) The provision of health care services to an individual; or

(iii) Payment for the provision of health care services to an individual.

(u) "Independent review organization" means an entity that conducts independent external reviews of claim denials.

(v) "Medical services" or "health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease or an admission, availability of care, continued stay or other care provided by a facility.

(w) "Medically necessary" includes but is not limited to "medical necessity" as defined by W.S. § 26-40-102(a)(iii).

(x) "NAIC" means the National Association of Insurance Commissioners.

(y) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(z) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

(aa) "Protected health information" means health information:

(i) That identifies an individual who is the subject of the information; or

(ii) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(bb) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(cc) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(dd) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(ee) "Utilization review organization" means an entity that conducts utilization review, other than an insurance carrier performing a review for its own insurance policies.

Section 4. Applicability and Scope

(a) Except as provided in subsection (b), this Rule shall apply to all insurance carriers.

(b) The provisions of this Rule shall not apply to a policy or certificate that provides coverage for long-term care insurance, as defined by W. S. § 26-38-103, or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, Wyoming Workers' Compensation or automobile medical-payment insurance.

Section 5. Notice of Right to Review

(a) An insurance carrier shall notify the claimant in writing of the claimant's right to request a review of any claim denied on the basis of not being medically necessary or on a similar basis. The notice shall include the appropriate statement and information set forth in subsection (b). The notice shall be sent to the claimant each time and at the same time as an insurance carrier sends written notice of the denial of claim on the basis of medical necessity or other similar basis.

(b) The notice of right to review shall include:

(i) Notice of the right to an internal review by the insurer which shall include:

(A) That the request for an internal review must be filed within thirty (30) days of the date the claimant received the denial of claim;

(B) That the claimant may submit additional information that relates to the claim;

(C) That the claimant may request the signed opinion of at least one (1) health care professional who is not an employee of the insurer;

(D) The procedure for filing the request for internal review; and

(E) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(ii) Notice of the right to an external review by an Independent Review Organization approved by the commissioner which shall include the following or substantially equivalent language:

(A) "We have denied your request for the provision of or payment for a health care service or course of treatment. After completion of an internal review, you may have the right to have our decision reviewed by health care professionals who have no association with us and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice."

(B) That the request must be made within one hundred twenty (120) days of the receipt of the notice of claim denial following the completion of the internal review;

(C) That the request for review shall be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity;

(D) That the request shall be made in duplicate and include a fee of fifteen dollars ($15.00) payable by check or money order to the Office of the Wyoming State Treasurer.

(I) The fee may be waived for a claimant whose income is at or below the current federal poverty level guidelines and who files a financial hardship application available upon request from the Wyoming Insurance Department.

(E) That the insurer shall be responsible for the costs of an external review by an independent review organization; and

(F) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(iii) Notice of the right to an internal and external expedited review which shall include:

(A) A statement that the expedited review shall be completed as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

(I) 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

(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 facility.

(B) That the request for internal expedited review shall be filed pursuant to the requirements of the insurer. A request for external expedited review must be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity and of the need for an expedited review.

(c) As part of any notice required by this Rule, the insurer shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the claimant, for purposes of conducting an external review under this Rule, authorizes the insurer and the claimant's treating health care provider to disclose protected health information, including medical records, concerning the claimant that are pertinent to the external review.

Section 6. Request for External Review

(a) All requests for external review shall be made in writing to the insurer, on a form approved by the commissioner, together with a copy and fee of fifteen dollars

($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on fees of seventy-five dollars ($75.00) per calendar year.

(b) A claimant or the claimant's authorized representative may make a request for an external review of a denied claim or final denied claim.

(c) A claimant or the claimant's authorized representative may submit additional new information with the request for external review for consideration during the external review process.

(d) The request for external review shall be accompanied by a health care professional certification of medical necessity.

(e) The request for an expedited review shall be accompanied by a health care professional certification of need for expedited review.

Section 7. Exhaustion of Internal Review Process

(a) Except as provided in subsection (d), a request for an external review pursuant to Section 6 of this Rule shall not be made until the claimant has exhausted the insurer's internal review process required by W.S. § 26-40-201(b)(iii).

(b) A claimant shall be considered to have exhausted the insurer's internal review process for purposes of this section, if the claimant or the claimant's authorized representative:

(i) Has filed a request for internal review involving a denied claim; and

(ii) Except to the extent the claimant or the claimant's authorized representative requested or agreed to a delay, has not received a written decision on the request for internal review from the insurer within forty five (45) days following the date the claimant or the claimant's authorized representative filed the request for internal review with the insurer.

(c) Notwithstanding paragraph (b), a claimant or the claimant's authorized representative may not make a request for an external review of a denied claim involving a retrospective review determination until the claimant has exhausted the insurance carrier's internal review process.

(d) At the same time a claimant or the claimant's authorized representative files a request for an expedited internal review of a denied claim, the claimant or the claimant's authorized representative may file a request for an expedited external review of the denied claim under Section 9 of this Rule if:

(i) the claimant has a medical condition where the timeframe for completion of an internal review of the denied claim 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 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.

(e) Upon receipt of a request for an expedited external review under subparagraph (d) of this section, the independent review organization conducting the external review in accordance with the provisions of Section 9 of this Rule shall determine whether the claimant shall be required to complete the expedited internal review process before it conducts the expedited external review.

(i) Upon a determination that the claimant must first complete the expedited internal review process the independent review organization immediately shall notify the claimant and, if applicable, the claimant's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 9 of this Rule until completion of the expedited internal review process and the expedited internal review process remains unresolved.

(f) A request for an external review of a denied claim may be made before the claimant has exhausted the health carrier's internal review procedures whenever the insurer agrees to waive the exhaustion requirement.

Section 8. Standard External Review

(a) Within one hundred twenty (120) days after the date of receipt of a notice of a denial of claim pursuant to Section 5 of this Rule, a claimant or the claimant's authorized representative may file a request for an external review with the insurer on a form approved by the commissioner.

(b) Within five (5) business days after the date of receipt of a request for external review pursuant to paragraph (a), the insurer shall send a copy of the request to the commissioner together with the fee.

(c) Within five (5) business days following the date of receipt of the external review request from the claimant, the insurer shall complete a preliminary review of the request to determine whether:

(i) The individual is or was a claimant in the insurance policy at the time the health care service was requested or, in the case of a retrospective review, was a claimant in the insurance policy at the time the health care service was provided;

(ii) The health care service that is the subject of the claim denial is a covered service under the claimant's insurance policy, but for a determination by the insurer that the health care service is not covered because it does not meet the requirements for medical necessity or other similar basis;

(iii) The claimant has exhausted the insurer's internal review process unless the claimant is not required to exhaust the insurer's internal review process pursuant to Section 7 of this Rule; and

(iv) The claimant has provided all the information, forms and fee required to process an external review, including the release form provided under Section 5(c) of this Rule.

(d) Within one (1) business day after completion of the preliminary review, the insurer shall notify the commissioner and claimant and, if applicable, the claimant's authorized representative in writing whether:

(i) The request is complete; and

(ii) The request is eligible for external review.

(e) If the request:

(i) Is not complete, the insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner 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 insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

(A) The commissioner may specify the form for the insurer's notice of determination that the request for standard external review is ineligible for review.

(B) The notice of determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative of the insurer's determination that the external review request is ineligible for review and may be appealed to the commissioner.

(f) The commissioner may determine that a request is eligible for external review under Section 8 of this Rule notwithstanding a insurer's determination that the request is ineligible and require that it be referred for external review.

(g) In making a determination under subparagraph (f) of this section, the commissioner's decision shall be made in accordance with the terms of the claimant's insurance policy and shall be subject to all applicable provisions of W. S. §§ 26-40-102(a) and 26-40-201.

(h) Whenever the insurance carrier determines that a request is eligible for external review following the preliminary review conducted pursuant to subsection (c), or that the claimant has provided the information requested to make their submission complete as required by paragraph (e)(i) of this section, the carrier shall, within one (1) business day of making such determination:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule to conduct the external review and notify the commissioner of the name of the assigned independent review organization; and

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

(i) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the insurer's review process as set forth in the internal review process.

(j) The insurance carrier shall include in the notice that the claimant or the claimant's authorized representative may submit in writing to the assigned independent review organization additional information for consideration by the independent review organization. Such information shall be submitted within five (5) business days following the date of receipt of the notice. Once the assigned independent review organization receives additional information from the claimant, the independent review organization will forward the information to the issuer within one (1) business day of receipt.

(k) Within five (5) business days after the determination by the insurer that the external review request is eligible for external review as identified in paragraph (h) of this section, , the insurance carrier or its designated utilization review organization shall provide to the assigned independent review organization the health information considered in making the claim denial.

(l) Except as provided in paragraph (e), failure by the insurer or its utilization review organization to provide the health information within the time specified in paragraph (k) shall not delay the conduct of the external review.

(m) The independent review organization shall within five (5) days of receipt of the external review request from the insurer determine whether the documentation is complete and immediately notify the claimant and the insurer in writing what information is missing, if any.

(n) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (k) and any other health information submitted in writing to the independent review organization by the claimant or the claimant's authorized representative pursuant to subsection (j).

(o) The insurance carrier may reconsider its denial of the claim at any point prior to the completion of the external review.

(p) Reconsideration by the insurer of its denial of claim determination pursuant to paragraph (o) shall not delay or terminate the external review.

(q) The external review may only be terminated if the insurance carrier decides, upon completion of its reconsideration, to reverse its denial of claim and provide coverage or payment for the health care service that is the subject of the denied claim.

(i) Within one (1) business day after making the decision to reverse its claim denial, as provided in paragraph (q), the insurer shall notify the claimant and, if applicable, the claimant's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the insurance carrier that the claim denial has been reversed.

(r) In addition to the health information provided pursuant to subsection (k), the assigned independent review organization, to the extent the health information is

available and the independent review organization considers them appropriate, shall consider the following in reaching a 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, the claimant's authorized representative, or the claimant's treating provider;

(iv) The terms of coverage under the claimant's 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.

(s) Within forty-five (45) 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 denial of claim as medically necessary, to:

(i) The claimant;

(ii) If applicable, the claimant's authorized representative;

(iii) The insurance carrier; and

(iv) The commissioner.

(t) The independent review organization shall include in the notice sent pursuant to paragraph (s):

(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 external review;

(iii) The date the external review was conducted;

(iv) The date of its decision;

(v)The principal reason or reasons for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or health information that they considered in reaching their conclusion, including references to how W.S. § 26-40-102 applies to the information reviewed.

(u) Upon receipt of a notice of a decision pursuant to paragraph (s) reversing the denial of claim, the insurance carrier within five (5) business days shall approve the covered benefit that was the subject of the denied claim.

(v) Upon receipt of a notice of decision pursuant to paragraph (s) reversing the denial of a claim, the commissioner shall refund the fee to the claimant.

(w) The assignment by the insurer of an approved independent review organization shall be on a rotational basis established by the commissioner.

Section 9. Expedited External Review

(a) A claimant or the claimant's authorized representative may make a request for an expedited external review with the commissioner at the time the claimant receives:

(i) A denial of claim if:

(A) The denied claim involves a medical condition of the claimant for which the timeframe for completion of an expedited internal review of a claim denial, if a standard external 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; and

(C) The claimant or the claimant's authorized representative has filed a request for an expedited review of a claim denial as not being medically necessary or on a similar basis.

(b) The request shall be made in duplicate and include a fee of fifteen dollars ($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on fees of seventy-five dollars ($75.00).

(i) Upon receipt of a request for an expedited external review, the insurer immediately shall send a copy of the request and the fee to the commissioner;

(ii) Immediately upon receipt of the request pursuant to paragraph (i), the insurance carrier shall determine whether the request meets the reviewability requirements set forth in Section 8(c)(i) through 8(c)(iv) of this Rule. The insurance carrier shall immediately notify the commissioner and the claimant and, if applicable, the claimant's authorized representative of its eligibility determination.

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

(i) The notice of initial determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative that a insurer's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(d) The commissioner may determine that a request is eligible for expedited external review notwithstanding an insurance carrier's initial determination that the request is ineligible and require that it be referred for expedited external review.

(e) In making a determination under paragraph (d) of this section, the commissioner's decision shall be made in accordance with the terms of the claimant's insurance policy and shall be subject to all applicable provisions of this Rule.

(f) Upon determination that the request meets the reviewability requirements, the insurer immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule. The insurer shall immediately notify the commissioner of the name of the assigned independent review organization.

(g) Upon receipt of the request for expedited external review, the insurance carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the denial of claim to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(h) 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 that meets the reviewability requirements set forth in Section 8c)(i) through 8(c)(iv) of this Rule, the assigned independent review organization shall:

(i) Make a decision to uphold or reverse the denial of claim; and

(ii) Notify the claimant and, if applicable, the claimant's authorized representative, the insurance carrier, and the commissioner of the decision.

(iii) The assigned independent review organization is not bound by any decisions or conclusions reached during the insurance carrier's internal review process.

(i) If the notice provided pursuant to paragraph (h) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(i) Provide written confirmation of the decision to the claimant and, if applicable, the claimant's authorized representative, the insurer, and the commissioner; and

(ii) Include the information set forth in Section 8(t) of this Rule.

(j) Upon receipt of the notice of a decision pursuant to paragraph (i) reversing the denial of claim, the insurance carrier immediately shall approve the covered benefit that was the subject of the denied claim.

(k) An expedited external review may not be provided for retrospective claim denials.

(l) The assignment by the insurer of an approved independent review organization shall be on the same basis as provided in Section 8(w).

Section 10. Binding Nature of External Review Decision

(a) An external (or expedited) review decision is binding on the insurance carrier except to the extent the insurance carrier has other remedies available under applicable state law.

(b) An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

(c) A claimant or the claimant's authorized representative may not file a subsequent request for external review involving the same denied claim for which the claimant has already received an external review decision pursuant to W.S. § 26-40-201.

Section 11. Approval of Independent Review Organizations

(a) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under W.S. § 26-40-201.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews an independent review organization:

(i) Shall be accredited by Utilization Review Accreditation Commission (URAC) or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section 12 of this Rule; and

(ii) Shall submit an application for approval in accordance with subsection (c).

(c) The commissioner shall develop an application form for initially approving and for re-approving independent review organizations to conduct external reviews.

(d) Any independent review organization wishing to be approved to conduct external reviews under this Rule shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 12 of this Rule.

(e) Subject to subparagraph (i) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by URAC or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section 12 of this Rule.

(i) The commissioner may approve independent review organizations that are not accredited by URAC or another nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(ii) The independent review organization shall submit an application fee in the sum of one hundred dollars ($100.00) to the commissioner with an application for approval and re-approval.

(iii) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Section 12 of this Rule.

(iv) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 12 of this Rule, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Rule that is maintained by the commissioner pursuant to subsection (f).

(f) The commissioner shall maintain and update a list of approved independent review organizations within fifteen (15) days of approval or determination of eligibility.

Section 12. Minimum Qualifications for Independent Review Organizations

(a) To be approved under Section 11 of this Rule to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Rule that include, at a minimum:

(i) A quality assurance mechanism in place that:

(A) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Rule;

(ii) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(iii) Agree to maintain and provide to the commissioner the information set out in Section 14 of this Rule.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be health care professionals or other appropriate health care providers who meet the following minimum qualifications:

(i) Be an expert in the treatment of the claimant’s medical condition that is the subject of the external review;

(ii) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the claimant;

(iii) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(iv) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in paragraph (a) of this section an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a insurance policy, a national, state or local trade association of insurance policies, or a national, state or local trade association of health care providers.

(d) In addition to the requirements set forth in paragraph (a), (b) and (c) of this section, to be approved pursuant to Section 11 of this Rule to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(i) The insurer that is the subject of the external review;

(ii) The claimant whose treatment is the subject of the external review or the claimant's authorized representative;

(iii) Any officer, director or management employee of the insurer that is the subject of the external review;

(iv) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(v)The facility at which the recommended health care service or treatment would be provided; or

(vi) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the claimant whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (d) of this section, the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical

reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(f) An independent review organization that is accredited by URAC or another nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 11 of this Rule.

(g) The commissioner shall initially review and periodically review the independent review organization accreditation standards of URAC and other nationally recognized private accrediting entities to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

(h) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(i) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Section 13. Hold Harmless for Independent Review Organizations

(a) No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Rule, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 14. External Review Reporting Requirements

(a) An independent review organization assigned pursuant to Section 8 or Section 9 of this Rule to conduct an external review shall maintain written records grouped by assigning insurer on all Wyoming requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under paragraph (b) of this section.

(b) Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (a) of this section for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(c) The report shall include in the aggregate and for each insurance carrier:

(i) The total number of requests for external review;

(ii) The number of requests for external review resolved and, of those resolved, the number resolved upholding the denied claim or final denied claim and the number resolved reversing the denied claim or final denied claim;

(iii) The average length of time for resolution;

(iv) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(v)The number of external reviews pursuant to Section 8 of this Rule that were terminated as the result of a reconsideration by the insurer of its denied claim or final denied claim after the receipt of additional information from the claimant or the claimant's authorized representative; and

(vi) Any other information the commissioner may request or require.

(d) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

(e) Each insurer shall maintain written records in the aggregate, and for each type of insurance policy offered by the insurer on all requests for external review that the insurer receives notice of from the insurers pursuant to W.S. § 26-40-201.

(f) Each insurer required to maintain written records on all requests for external review pursuant to paragraph (a) of this section shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(i) The report shall include in the aggregate and by type of insurance policy:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subparagraph (A) of this paragraph, the number of requests determined eligible for a full external review; and

(C) Any other information the commissioner may request or require.

(g) The insurer shall retain the written records required pursuant to this subsection for at least five (5) years.

Section 15. Funding of External Review

(a) The insurance carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 16. Disclosure Requirements

(a) Each insurance carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to claimants.

(b) The description required under subsection (a) shall include a statement that informs the claimant of the right of the claimant to file a request for an internal or external review in compliance with W.S. § 26-40-201.

(c) In addition to subsection (b), the statement shall inform the claimant that, when filing a request for an external review, the claimant will be required to authorize the release of any medical records of the claimant that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 17. Severability

(a) If any provision of this Rule, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 18. Enforceability

Section 19. Any violation of these regulations shall be enforceable pursuant to the provisions of W.S. §26-1-107, W.S. §26-3-116, W.S. §26-9-211, and any other applicable rule or statute.

Section 20. Effective Date

(a) This Rule shall become effective upon filing with the Secretary of State.