State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment _x_; Repeal ___; Repeal and Reenact ___		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R590-261**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Insurance	
Agency:	Administration	
Room number:	Suite 2300	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state and zip:	Taylorsville, UT 84129	
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City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:

R590-261. Health Benefit Plan Adverse Benefit Determinations

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of minor issues that needed to be amended.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, remove the Penalties and Enforcement Date sections, and update the Severability section to use the department's current language. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2023**	**FY2024**	**FY2025**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of Insurance, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-2-212	Section 31A-22-629

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**

A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	

Issue Date	
Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		**05/01/2023**
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	**05/08/2023**
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Steve Gooch, Public Information Officer	**Date:**	**03/06/2023**

R590. Insurance, Administration.
R590-261. Health Benefit Plan Adverse Benefit Determinations.
R590-261-1. Authority.

This rule is promulgated by the commissioner pursuant to [~~Subsection 31A-22-629(4) which requires the commissioner to adopt rules that establish standards for independent reviews, Subsection 31A-2-201(3)(a) wherein the commissioner may make rules to implement the provisions of Title 31A and 31A-2-212(5)(b) wherein the commissioner requires compliance with the Patient Protection and Affordable Care Act~~]Sections 31A-2-201, 31A-2-212, and 31A-22-629.

~~**[R590-261-2. Purpose.**~~

~~The purpose of this rule is to provide a uniform standard for the establishment and maintenance of an independent review procedure to assure that a claimant has the opportunity for an independent review of a final adverse benefit determination.~~

~~**R590-261-3. Scope.**~~

~~(1) Except as provided in Subsection (2), this rule applies to all health benefit plans as defined in 31A-1-301 except for a grandfathered health plan as defined in 45 CFR 147.140.~~

~~(2) If all grandfathered health benefit plans are administered consistently, a carrier may, for the grandfathered health benefit plans, voluntarily comply with the independent review process set forth in this rule, otherwise a grandfathered health benefit plan is subject to R590-203.~~

~~(3) A self-funded health plan may voluntarily comply with the independent review process set forth in this rule.~~]

R590-261-2. Purpose and Scope.

(1) The purpose of this rule is to provide a uniform standard for the establishment and maintenance of an independent review procedure to assure that a claimant has the opportunity for an independent review of a final adverse benefit determination.

(2)(a) This rule applies to a carrier offering a health benefit plan.

(b) This rule does not apply to a grandfathered health plan.

(c) If all grandfathered health benefit plans are administered consistently, a carrier may voluntarily comply with the independent review process outlined in this rule.

(d) A self-funded health plan may voluntarily comply with the independent review process outlined in this rule.

R590-261-[4]3. Definitions.

[~~In addition to the definitions in Section 31A-1-301, the following definitions apply for purposes of this rule~~]Terms used in this rule are defined in Section 31A-1-301 and 45 CFR 147.140. Additional terms are defined as follows:

(1)(a) "Adverse benefit determination" means:

(i) based on the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or

effectiveness of a covered benefit, the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or part, for a benefit; or

(ii) rescission of coverage.

(b) "Adverse benefit determination" includes:

(i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(ii) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

(iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(A) experimental;

(B) investigational; or

(C) not medically necessary or appropriate.

(2) "Authorized representative" means:

(a) a person to whom an insured has given express written consent for representation in an external review;

(b) a person authorized by law to provide substituted consent for an insured; or

(c) when the insured is unable to provide consent:

(i) a family member of the insured; or

(ii) the insured's treating health care provider.

[~~(2)~~](3) "Carrier" means [~~any~~]a person [~~or entity~~]that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person [~~or entity~~]providing a health insurance plan under Title 31A, Insurance Code.

[~~(3)~~](4) "Claimant" means [~~an insured or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy~~]the insured or the insured's authorized representative.

[~~(4)~~](5) "Clinical reviewer" means a physician or other appropriate health care provider who:

(a) is an expert in the treatment of the [~~insured's~~]medical condition that is the subject of the review;

(b) is 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;

(c) holds an appropriate license or certification; and

(d) has no history of disciplinary actions or sanctions.

[~~(5)~~](6) "Final adverse benefit determination" means an adverse benefit determination that has been upheld by a carrier at the completion of the carrier's internal review process.

[~~(6)~~](7) "Independent review" means a process that:

(a) is a voluntary option for the resolution of a final adverse benefit determination;

(b) is conducted at the discretion of the claimant;

(c) is conducted by an independent review organization designated by the commissioner;

(d) renders an independent and impartial decision on a final adverse benefit determination; and

(e) may not require the claimant to pay a fee for requesting the independent review.

[~~(7)~~](8)(a) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(b) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward[~~s~~] the cost of coverage.

R590-261-[~~5~~]4. Adverse Benefit Determination Procedure Compliance.

An adverse benefit determination procedure shall [~~be compliant~~]comply with this rule[~~ and the requirements for adverse benefit determinations set forth in~~] , 29 CFR 2560.503-1, and 45 CFR 147.136.

R590-261-[~~6~~]5. Notice of Right to Independent Review.

(1) [~~With each~~]A carrier shall provide written notice of a claimant's right to an independent review with each notice of [~~a~~]rescission of coverage or final adverse benefit determination[~~, the carrier shall provide written notice of the claimant's right for an independent review of the determination~~].

(2) The notice in Subsection (1) shall include the following, or substantially equivalent, statement:

"We have rescinded your coverage or 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 a health care professional who has no association with us if

our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, visit https://insurance.utah.gov/consumer/health/independent-review or contact the Utah Insurance [~~Commissioner~~]Department by mail at 4315 S. 2700 W., Suite 2300, Taylorsville, UT 84129; by phone at 801-957-9280; or [~~electronically~~]by email at healthappeals[~~aid~~]@utah.gov."

R590-261-[~~7~~]6. Exhaustion of Internal Review Process.

[~~The~~]A carrier's internal review process shall be exhausted [~~prior to~~]before an independent review unless:

(1) the carrier agrees to waive the internal review process;

(2) the carrier [~~has not complied~~]did not comply with [~~the requirements for the carrier's~~]its internal review process, except for [~~those failures to comply that are based on de minimis violations that do~~]a minor violation that:

(a) does not cause[~~, and are not likely to cause,~~] prejudice or harm to the claimant; and[~~are~~]

(b) is not part of a pattern or practice of violations; or

(3) the claimant [~~has requested~~]requests an expedited independent review pursuant to Section [~~11~~]R590-261-10 at the same time [~~as requesting~~]the claimant requests an expedited internal review.

R590-261-[~~8~~]7. Independent Review Organizations.

(1) The commissioner shall compile and maintain a list of approved independent review organizations.

(2) To be considered for placement on the list [~~of approved independent review organizations~~]in Subsection (1), an independent review organization shall:

(a) be accredited by a nationally recognized private accrediting entity;

(b) [~~meet~~]comply with the requirements of this rule; and

(c) [~~have~~]establish and maintain written policies and procedures that ensure:

(i) [~~that~~]all reviews are conducted within [~~the~~]a specified time frame[~~s~~];

(ii) [~~the selection of~~]a clinical reviewer is qualified and impartial[~~clinical reviewers~~];

(iii) [~~the~~]confidentiality of medical and treatment records and clinical review criteria; and

(iv) [~~that~~]any person employed by or under contract with the independent review organization adheres to the requirements of this rule.

(3) An applicant requesting placement on the list [~~of approved independent review organizations~~]in Subsection (1) shall submit [~~for the commissioner's review~~]to the commissioner:

(a) [~~the~~]a completed Independent Review Organization Application form, available on [~~our website at www.~~]the department's website, https://insurance.utah.gov;

(b) all documentation and information requested on the application, including proof of [~~being accredited~~]accreditation by a nationally recognized private accrediting entity; and

(c) [~~the~~]an application fee.

(4) [~~The commissioner shall terminate the approval of an~~]An independent review organization shall be removed from the list in Subsection (1) if the commissioner [~~determines~~]finds that the independent review organization [~~has~~]lost its accreditation or no longer satisfies the minimum requirements for approval.

(5)(a) An independent review organization may not [~~own or control, or be owned or controlled by~~]be owned or controlled by, or exercise control over:

(i) a carrier;

(ii) a health benefit plan;

(iii) a health benefit plan's fiduciary;

[~~(iv) an employer or sponsor of a health benefit plan;~~]

[~~(v)~~](iv) a national, state, or local trade association of:

(A) health benefit plans;

(B) carriers; or

(C) health care providers;[~~or~~]

(v) an employer; or

(vi) an employee or agent of [~~any one~~]a person listed in Subsections (5)(a)(i) through (5)(a)(v).

(b) An independent review organization and [~~the~~]a clinical reviewer assigned to conduct an independent review may not have a [~~material~~]professional, familial, or financial conflict of interest with:

(i) the carrier;

(ii) an officer, director, or management employee of the [~~carrier~~]health plan;

(iii) the health benefit plan;

(iv) the plan administrator, plan [~~fiduciaries~~]fiduciary, or a plan employee[~~s~~];

(v) the [~~insured or~~]claimant;

(vi) the insured's health care provider;

(vii) the health care provider's medical group or independent practice association;

(viii) [~~a~~]the health care facility where the service [~~would be~~]is provided; or

(ix) the developer or manufacturer of the service that [~~would be~~]is provided.

R590-261-[~~9~~]8. General Independent Review Requirements.

[~~The requirements of this section shall apply in addition to the requirements for a standard independent review, an expedited independent review and an independent review of experimental or investigational service or treatment.~~

~~(1) The carrier shall pay the cost of the independent review organization for conducting the independent review.~~]

[~~(2)~~](1) An independent review is available to [~~the~~]a claimant regardless of the dollar amount of the claim involved.

[~~(3)(a) The claimant shall have~~](2)(a) A claimant has 180 calendar days after [~~the receipt of~~]receiving a notice of a final adverse benefit determination to file a request with the commissioner for an independent review.

(b) [~~The~~]A claimant shall use the Independent Review Request Form available on [~~our website at www.~~]the department's website, https://insurance.utah.gov, or a substantially similar form, to file [~~the~~]a request.

(c) A request for an independent review sent to [~~the~~]a carrier instead of to the commissioner shall be forwarded to the commissioner by the carrier within one business day of receipt.

(3) A carrier shall pay to the independent review organization the cost of conducting the independent review.

(4) The independent review decision is binding on the carrier and the claimant except to the extent that other remedies are available under federal or state law.

(5)(a) If a carrier fails to provide the requested information to an independent review organization, as outlined in Subsections R590-261-9(2)(b), R590-261-10(3)(b), and R590-261-11(3)(b), the independent review organization may terminate the independent review and make a decision to reverse the adverse benefit determination.

(b) Within one business day after making a decision under Subsection (5)(a), the independent review organization shall notify:

(i) the claimant;

(ii) the carrier; and

(iii) the commissioner.

R590-261-[~~10~~]9. Standard Independent Review.

(1)(a) Upon [~~receipt of~~]receiving a request for an independent review, the commissioner shall send a copy of the request to the carrier for an eligibility review.

(b) Within five business days [~~following receipt of the copy of~~]after receiving the request, the carrier shall determine [~~whether~~]if:

(i) the individual [~~is or~~]was an insured in the health benefit plan at the time:

(A) of rescission; or

(B) the health care service was requested or provided;

(ii) [~~if a~~]the health care service is [~~the subject of the adverse benefit determination, the health care service is~~]a covered [~~expense~~]benefit;

(iii) the claimant [~~has~~]exhausted the carrier's internal review process; and

(iv) the claimant [~~has~~]provided [~~all~~]the information and forms required to process an independent review.

(c)(i) Within one business day after [~~completion of~~]completing the eligibility review, the carrier shall notify the commissioner and claimant in writing [~~whether~~]if:

(A) the request is complete; and

(B) the request is eligible for independent review.

[~~(ii) If the request:~~]

[~~(A)~~](ii) If the request is not complete, the carrier shall inform the claimant and the commissioner, in writing, [~~what~~]of the information or materials [~~are~~]needed to make the request complete[~~; or~~].

[~~(B) is not eligible for independent review, the carrier shall:~~

~~(I) inform the claimant and commissioner in writing the reasons for ineligibility; and~~

~~(II) inform the claimant that the determination may be appealed to the commissioner.~~]

(iii) If the request is not eligible for independent review, the carrier shall:

(A) inform the claimant and the commissioner, in writing, of the reasons for ineligibility; and

(B) inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review, notwithstanding the carrier's initial determination that the request is ineligible, and may require that the request be referred for independent review.

(ii) In making the determination in Subsection (1)(d)(i), the commissioner's decision shall be made in accordance with the terms of the insured's health benefit plan and shall be subject to all applicable provisions of this rule.

(2) Upon [~~receipt of the~~]receiving a carrier's determination that [~~the~~]a request is eligible for an independent review, the commissioner shall:

(a) assign, on a random basis, an independent review organization from the list of approved independent review organizations based on the nature of the health care service that is the subject of the review;

(b) notify the carrier of the assignment and that the carrier shall, within five business days, provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that:

(i) the request [~~has been~~]for independent review is accepted; and[~~ that~~]

(ii) the claimant may submit additional information to the independent review organization within five business days of [~~receipt of~~]receiving the commissioner's notification.

(3) The independent review organization shall forward any additional information submitted by a claimant under Subsection (2)(c) to the carrier within one business day of receipt[~~any information submitted by the claimant~~].

[~~(3)~~](4) Within 45 calendar days after [~~receipt of the~~]receiving a request for an independent review, the independent review organization shall provide written notice of its decision [~~to uphold or reverse the adverse benefit determination~~]to:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

[~~(4)~~](5) Within one business day of [~~receipt of~~]receiving notice that an adverse benefit determination [~~has been~~]is overturned, the carrier shall:

(a) approve the coverage that [~~was~~]is the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-[~~11~~]10. Expedited Independent Review.

(1) An expedited independent review process shall be available if the adverse benefit determination:

(a) involves [~~a~~]an insured's medical condition [~~of the insured which would~~]that may seriously jeopardize the life or health of the insured or [~~would jeopardize~~]the insured's ability to regain maximum function;

(b) may, in the opinion of the insured's attending provider, [~~would~~]subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or

(c) [~~concerns~~]involves an admission, availability of care, continued stay, or health care service for which the insured received emergency medical services, but has not been discharged from a facility.

(2)(a) Upon [~~receipt of~~]receiving a request for an expedited independent review, the commissioner shall immediately send a copy of the request to the carrier for an eligibility review.

(b) Immediately upon [~~receipt of~~]receiving the request, the carrier shall determine [~~whether~~]if:

(i) the individual [~~is or~~]was an insured in the health benefit plan at the time the health care service was requested or provided;

(ii) the health care service [~~that is the subject of the adverse benefit determination~~]is a covered [~~expense~~]benefit; and

(iii) the claimant [~~has~~]provided [~~all~~]the information and forms required to process an expedited independent review.

(c)(i) The carrier shall immediately notify the [~~commissioner and claimant whether~~]claimant and the commissioner if:

(A) the request is complete; and

(B) the request is eligible for an expedited independent review.

[~~(ii) If the request:~~]

[~~(A)~~](ii) If the request is not complete, the carrier shall inform the claimant and the commissioner, in writing[~~what~~], of the information or materials [~~are~~]needed to make the request complete[~~; or~~].

[~~(B) is not eligible for independent review, the carrier shall:~~

~~(I) inform the claimant and commissioner in writing the reasons for ineligibility; and~~

~~(II) inform the claimant that the determination may be appealed to the commissioner.~~]

(iii) If the request is not eligible for an expedited independent review, the carrier shall:

(A) inform the claimant and the commissioner, in writing, of the reasons for ineligibility; and

(B) inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for an expedited independent review, notwithstanding the carrier's initial determination that the request is ineligible, and [~~shall~~]may require that the request be referred for an expedited independent review.

(ii) In making the determination in Subsection (2)(d)(i), the commissioner's decision shall be made in accordance with the terms of the insured's health benefit plan and shall be subject to [~~all applicable provisions of~~]this rule.

(3) Upon [~~receipt of~~]receiving the carrier's determination that [~~the~~]a request is eligible for an expedited independent review, the commissioner shall immediately:

(a) assign an independent review organization from the list of approved independent review organizations;

(b) notify the carrier of the assignment and that the carrier shall[~~within one business day~~], upon receipt, provide to the assigned independent review organization [~~all~~]the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that:

(i) the request [~~has been~~]is accepted; and[~~that~~]

(ii) the claimant may [~~within one business day~~]immediately submit additional information to the independent review organization.

(4) The independent review organization shall forward any additional information submitted by a claimant under Subsection (3)(c)(ii) to the carrier within one business day of receipt[~~any information submitted by the claimant~~].

[~~(4)(a) The independent review organization shall as soon as possible, but no later than 72 hours after receipt of~~](5)(a) As expeditiously as the insured's medical condition or circumstance requires, but no later than 72 hours after receiving the request for an expedited independent review, [~~make a decision to uphold or reverse the adverse benefit determination and shall notify~~]the independent review organization shall provide notice of its decision to:

(i) the carrier;

(ii) the claimant; and

(iii) the commissioner.

(b) If notice of the independent review organization's decision is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of [~~the~~]notification[~~ of the decision~~].

[~~(5) Within one business day of receipt of~~](6) Upon receiving notice that an adverse benefit determination [~~has been~~]is overturned, the carrier shall:

(a) approve the coverage that [~~was~~]is the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-[~~12~~]11. Independent Review of Experimental or Investigational Service or Treatment[~~ Adverse Benefit Determinations~~].

(1)(a) A request for an independent review, based on an experimental or investigational service or treatment, shall be submitted with certification from the insured's [~~physician~~]health care provider that:

[~~(a)~~](i) the standard health care service or treatment [~~has not been~~]is not effective in improving the insured's condition;

[~~(b)~~](ii) the standard health care service or treatment is not medically appropriate for the insured; or

[~~(c)~~](iii) there is no available standard health care service or treatment covered by the carrier that is more beneficial than the recommended or requested health care service or treatment.

(b) A claimant may make an oral or written request for an expedited independent review if the insured's health care professional certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

(2)(a) [~~Upon receipt of~~]Within one business day after receiving a request for an independent review involving an experimental or investigational service or treatment, or immediately for an expedited review, the commissioner shall send a copy of the request to the carrier for an eligibility review.

(b) Within five business days [~~following receipt of the copy of~~]after receiving the request, [~~one business day~~]or immediately for an expedited review, the carrier shall determine [~~whether~~]if:

(i) the individual [~~is or~~]was an insured in the health benefit plan at the time the health care service was requested or provided;

(ii) the health care service or treatment [~~that is the subject of the adverse benefit determination~~]is a covered [~~expense~~]benefit, except for the carrier's determination that the service or treatment:

(A) is experimental or investigational for a particular medical condition; and

(B) is not explicitly listed as an excluded benefit under the insured's health benefit plan;

(iii) the insured's health care provider:

(A) has certified one of the following situations applies:

(I) the standard health care services have not been effective in improving the condition of the insured;

(II) the standard health care services or treatments are not medically appropriate for the covered person; or

(III) there is no available standard health care service or treatment covered by the carrier that is more beneficial than the recommended or requested health care service or treatment;

(B) has certified in writing:

(I) in their opinion, the health care service or treatment is likely to be more beneficial to the insured than any available standard health care service or treatment; and

(II) scientifically valid studies using accepted protocols demonstrate that the health care service or treatment is likely to be more beneficial to the insured than any available standard health care service or treatment; and

(C) is licensed, board certified, or board eligible to practice in the area of medicine appropriate to treat the insured's condition;

(iv) the claimant [~~has~~]exhausted the carrier's internal review process, unless the request is for an expedited review; and

[~~(iv)~~](v) the claimant [~~has~~]provided [~~all~~]the information and forms required to process [~~the~~]an independent review.

(c)(i) Within one business day after [~~completion of~~]completing the eligibility review, or immediately for an expedited review, the carrier shall notify the commissioner and the claimant, in writing[~~ whether~~], if:

(A) the request is complete; and

(B) the request is eligible for independent review.

[~~(ii) If the request:~~]

[~~(A)~~](ii) If the request is not complete, the carrier shall inform the claimant and commissioner, in writing[~~ what~~], of the information or materials [~~are~~]needed to make the request complete[~~; or~~].

[~~(B) is not eligible for independent review, the carrier shall:~~

~~(I) inform the claimant and commissioner in writing the reasons for ineligibility; and~~

~~(II) shall inform the claimant that the determination may be appealed to the commissioner.~~]

(iii) If the request is not eligible for independent review, the carrier shall:

(A) inform the claimant and the commissioner, in writing, of the reasons for ineligibility; and

(B) inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review, notwithstanding the carrier's initial determination that the request is ineligible, and require that the request be referred for independent review.

(ii) In making the determination in Subsection (2)(d)(i), the commissioner's decision shall be made in accordance with the terms of the health benefit plan and shall be subject to all applicable provisions of this rule.

(3) Upon [~~receipt of~~]receiving the carrier's determination that the request is eligible for an independent review, the commissioner shall:

(a) assign an independent review organization from the list of approved independent review organizations;

(b) notify the carrier of the assignment and that the carrier shall, within five business days, [~~one business day~~]or immediately for an expedited review, provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that the request has been accepted and that the claimant may, within five business days, [~~one business day~~]or immediately for an expedited review, submit additional information to the independent review organization.

(4) The independent review organization shall forward any additional information submitted by a claimant under Subsection (3)(c) to the carrier within one business day of receipt[~~- any information submitted by the claimant~~], or immediately for an expedited review.

[~~(4)~~](5) Within one business day after [~~receipt of~~]receiving the request, or immediately for an expedited review, the independent review organization shall select one or more clinical reviewers to conduct the review.

[~~(5)~~](6) The clinical reviewer shall provide to the independent review organization a written opinion within 20 calendar days, or five calendar days for an expedited review, after being selected.

[~~(6)~~](7) The independent review organization[~~- shall make a decision based on the clinical reviewer's opinion -~~], within 20 calendar days[~~,~~] of receiving the clinical reviewer's opinion, or no later than 72[~~48~~] hours for an expedited review, [~~of receiving the opinion and shall notify~~]shall provide notice of its decision to:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

[~~(7)~~](8) Within one business day of [~~receipt of~~]receiving notice that an adverse benefit determination [~~has been~~]is overturned, the carrier shall:

(a) approve the coverage that [~~was~~]is the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-[~~13~~]12. Disclosure Requirements.

(1) [~~Each~~]A carrier shall include a description of the independent review procedure in or attached to the policy and certificate, and may include a description with other evidence of coverage provided to the insured.

(2) The description required in Subsection (1) shall include a statement that informs the insured:

(a) of the right to file a request for an independent review of a final adverse benefit determination[~~- and include -~~], including the [~~contact information for the commissioner~~]website, phone number, and address of the Utah Insurance Department; and

(b) that an authorization to obtain medical records [~~shall be~~]is required for [~~the purpose of~~]reaching a decision.

R590-261-[~~14~~]13. Records.

(1) An independent review organization shall maintain a written record of each independent review for the current year plus [~~5~~]five years.

(2) The records of an independent review organization shall be available for review by the commissioner upon request.

~~**[R590-261-15. Penalties.**~~

~~A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.~~

~~**R590-261-16. Enforcement Date.**~~

~~The commissioner shall begin enforcing the revised provisions of this rule on the effective date.~~

]

R590-261-[~~17~~]14. Severability.

[~~If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~]If any provision of this rule, Rule R590-261, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

KEY: health benefit plan insurance
Date of Last Change: 2023[~~December 8, 2011~~]
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