

# COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN  
COMMISSIONER



OFFICE OF THE MONTANA  
STATE AUDITOR

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## ADVISORY MEMORANDUM

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**To:** All Health Insurance Carriers

**From:** Monica J. Lindeen, Commissioner of Securities and Insurance  
Office of the Montana State Auditor

**Date:** November 30, 2015

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### HEALTH INSURER OBLIGATIONS – UTILIZATION REVIEW, INTERNAL APPEAL, AND EXTERNAL REVIEW

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In 2015, the Montana Legislature passed Senate Bill 83 (SB83), now codified in Title 33, Chapter 32 of the Montana Code Annotated. SB83 adopted versions of three National Association of Insurance Commissioners (NAIC) model acts, including the Utilization Review and Benefit Determination Model Act, the Health Carrier Grievance Procedure Model Act, and the Uniform Health Carrier External Review Model Act. The legislation takes effect on January 1, 2016. The Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), issues this memorandum to provide health insurers with prospective guidance as to new reporting, filing, and disclosure obligations applicable to health insurers as a result of SB83.

#### Annual Reporting Deadlines

SB83 requires health insurers to provide to the CSI annual reports relating to both utilization review and internal appeals (also known as grievances). Section 33-32-207(3) requires annual filing of a summary of utilization review program activities. Section 33-32-306(7) requires a similar annual filing with respect to internal appeals. Insurers must file both reports in a format specified by the CSI.

Health insurers will be required to file their first utilization review and internal appeal annual reports no later than March 31, 2017. These reports shall reflect insurer

experience during the calendar year 2016. The CSI will not require annual reporting prior to March 31, 2017, to allow insurers to collect an entire year of data before the initial report. As the reporting deadline approaches, the CSI will issue guidance regarding the appropriate format of the utilization review and internal appeal annual reports.

#### Internal Appeal Documentation Filing

Section 33-32-307 also requires health insurers to file extensive documentation relating to internal appeals. This documentation includes copies of the insurer's written internal appeal procedures, including applicable forms used to process such requests, and a description of those internal appeal procedures, which must be included in policy documents. §§33-32-307(1), (4). The CSI requires that all health insurers doing business in Montana file these materials with the CSI no later than January 1, 2016. Insurers must file this documentation either emailing it in .pdf format to [SBarry@mt.gov](mailto:SBarry@mt.gov), or by mailing it to: Office of the Montana State Auditor, attn: Shanni Barry, 840 Helena Avenue, Helena, MT 59601.

#### Form Disclosures

SB83 requires disclosure in policy documents of health insurer procedures relating to utilization review, internal appeal, and external review. §§ 33-32-217, 33-32-307, 33-32-423. The CSI will not at this time prescribe specific language, or a specific format, which insurers must use to satisfy these disclosure requirements. See § 33-32-423 (external review disclosure must "be in a format prescribed by the [CSI]."). Instead, the CSI has developed a document setting forth information insurers must provide in policy documents. See Exhibit A. This document sets forth the minimum required disclosure; insurers are encouraged to include such additional information regarding these topics as is necessary to educate insureds regarding their rights and obligations.

Section 33-32-423(2)(b) requires that the external review disclosures include a statement advising the covered person of the right to file a request for external review with the CSI. This conflicts with other applicable law, which requires that such requests be filed directly with the health insurer. See §§ 33-32-410(1), 33-32-411(1), 33-32-412(1). The CSI may waive a particular provision found in an insurance policy form if the provision is "unnecessary for the protection of the insured and inconsistent with the purposes of the policy." § 33-15-301(1)(a). Additionally, a policy may not contain a provision "inconsistent with or contradictory to any standard or uniform provision," but the CSI may approve a suitable substitute. § 33-15-301(2).

The CSI finds that the required disclosure found in § 33-32-423(2)(b) is unnecessary, and inconsistent with and contradictory to the more specific external review procedures disclosed elsewhere in the policy documents. Therefore, in place of the disclosure required under § 33-32-423(2)(b), health insurers should provide a substitute provision. This provision should note that external reviews are filed with the insurer and should provide the insurer's contact information, but in all other respects should mirror the disclosure required under § 33-32-423(2)(b).

#### Experimental/Investigational External Review – Timing

The CSI has identified a drafting error in § 33-32-412, which addresses external reviews relating to experimental/investigational adverse benefit determinations. Subsection (11) states

(11) Within 1 business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (9), the assigned independent review organization shall:

(a) select a clinical peer, or multiple peers if medically appropriate under the circumstances, to conduct the external review; and

(b) make a decision, based on the opinion of the clinical peers, to uphold or reverse the adverse determination or final adverse determination.

Subsection (11)(b) is in error for two reasons. First, an IRO cannot reasonably receive an external review assignment, select clinical peers, and reach a determination within 1 business day. Second, § 33-32-412 sets forth the correct review timeframes elsewhere. Specifically, § 33-32-412(20) and (22) provide clinical peer response and IRO determination timeframes for both standard and expedited external reviews relating to experimental/investigational insurer determinations. Therefore, the CSI advises insurers and IROs to disregard the timeframe contemplated in § 33-32-412(11)(b), and to instead adhere to the timeframes described elsewhere in the statute.

For any questions regarding this advisory memorandum, call the CSI Legal Bureau at (406) 444-2040

## **Senate Bill 83: Insurer Disclosure Guidelines**

### **Utilization Review: Title 33, Chapter 32, Part 2**

*Mont. Code Ann. § 33-32-217: Certificate of coverage and member handbook must contain clear and comprehensive utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of insured rights and responsibilities with regard to those procedures.*

Policy documents must include the following information regarding utilization review:

- State that the insured has the right to request utilization review, including in cases involving urgent care services
- Provide the insured a toll-free or collect call telephone number for the insurer's utilization review staff
- Disclose the following utilization review deadlines, within which the insurer must complete its review:
  - For prospective determinations
  - For retrospective determinations
  - For expedited determinations
  - The insurer may seek a 15-day deadline extension for prospective and retrospective determinations.
- Explain how to appeal an adverse determination, such as an adverse utilization review determination.

### **Internal Appeal: Title 33, Chapter 32, Part 3**

*Mont. Code Ann. § 33-32-307: A health insurer shall use written procedures for receiving and resolving grievances. . . [such procedures] must be included in or attached to evidence of coverage.*

Policy documents must include the following information regarding internal appeals (also known as grievances):

- Disclose the right of the insured to an internal appeal of an adverse determination.
- State that the consumer has the right to contact the Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), for assistance with an appeal, and provide the CSI's address and telephone number
- Provide the address and telephone number of the insurer's internal appeals staff.
- State that the consumer has 180 days to request an internal appeal of an adverse determination.

- State that the individual conducting the review shall be independent and impartial.
- State that the insured has the right to
  - Submit additional information in support of his or her appeal.
  - Request, free of charge, copies of the materials relating to the request for benefits
- Disclose the following internal appeal deadlines, within which the insurer must complete its review:
  - Standard prospective appeal
  - Standard retrospective appeal
  - Expedited appeal

### **External Review (ER): Title 33, Chapter 32, Part 4**

*Mont. Code Ann. § 33-32-423 Each insurer shall include a description of ER procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage*

Policy documents must include the following information regarding external review

- State that the insured may request an external review of an adverse determination involving “an issue of medical necessity, appropriateness, health care setting, level of care, or level of effectiveness ”
- State that the insured has 120 days following the adverse determination to request external review.
- State that the insurer is required to disclose any information or documentation that insurer relied upon when making their decision
- Explain how to submit a request for external review, including that for cases involving expedited review, the insured may make the request orally.
- Provide the CSI address and telephone number (and specifically state that the CSI is available to assist consumers with their internal and external appeals).
- Explain the external review process, including.
  - The case will be assigned to an impartial independent review organization (IRO)
  - The insured may submit additional information to support claim
  - IRO, not insurer, will make final determination
- Disclose the following external review deadlines, within which the IRO must complete its review (these deadlines run from the day the IRO receives the request):
  - Standard external review
  - Expedited external review