Title 3. Commerce, Community, and Economic Development.

Part 2. Division of Insurance.

Chapter 28. Life, Health, Variable, and Related Insurance.

Article

1. Variable Contracts (3 AAC 28.010 – 3 AAC 28.190)
2. (Repealed)
3. (Repealed)
4. Consumer Credit Insurance (3 AAC 28.310 – 3 AAC 28.405)
5. Health Insurance Marketed as Medicare Supplements (3 AAC 28.410 – 3 AAC 28.510)
6. Group Health Insurance (3 AAC 28.520 – 3 AAC 28.525)
7. Mortality Tables (3 AAC 28.600 – 3 AAC 28.690)
8. Uniform Claim Forms (3 AAC 28.700 – 3 AAC 28.745)
9. Life Insurance Policy Illustrations (3 AAC 28.800 – 3 AAC 28.849)
10. **Utilization Review and Benefit Determinations (3 AAC 28.900 – 3 AAC 28.918)**
11. **Health Care Insurer Grievance Procedures (3AAC 28.930 – 3 AAC 28.938)**
12. **External Review of Health Care Coverage Decisions (3 AAC 28.950 – 3 AAC 28.982)**
13. **General Provisions (3 AAC 28.999)**

Article 10. Utilization Review and Benefit Determinations.

3 AAC 28 is amended by adding new sections to read:

Section

3 AAC 28.900. Applicability. 3 AAC 28.900 – 3 AAC 28.918 apply to

(1) a health care insurer that

(A) transacts health care insurance in this state; and

(B) provides or performs utilization review services;

(2) a designee of the health care insurer under (1) of this section including a utilization review organization that performs utilization review functions on the health care insurer's behalf; and

(3) a health care insurer under (1) of this section or the health care insurer's designee utilization review organization that provides or performs a prospective review or retrospective review benefit determination. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.902. Corporate oversight of utilization review program. A health care insurer shall

(1) monitor all utilization review activities carried out by, or on behalf of, the health care insurer;

(2) ensure the requirements of 3 AAC 28.900 – 3 AAC 28.918 are met; and

(3) ensure appropriate personnel have operational responsibility for the conduct of the health care insurer's utilization review program. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.904. Contracting. If a health care insurer contracts to have a utilization review organization or other entity perform the utilization review functions required under 3 AAC 28.900 – 3 AAC 28.918, the director shall

(1) hold the health care insurer responsible for monitoring the activities of the utilization review organization or entity with which the health care insurer contracts; and

(2) ensure the requirements of 3 AAC 28.900 – 3 AAC 28.918 are met. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.906. Scope and content of utilization review program. (a) A health care insurer that requires utilization review of a benefit request under a health care insurance policy shall develop and implement a written utilization review program that describes, at a minimum, the following utilization review activities:

(1) filing of a benefit request;

(2) notification to a covered person or the covered person's authorized representative of a utilization review and benefit determination;

(3) review of an adverse determination under 3 AAC 28.930 – 3 AAC 28.938.

(b) The written document required under (a) of this section must describe:

(1) procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

(2) data sources and clinical review criteria used in making a determination;

(3) procedures to ensure consistent application of clinical review criteria and compatible determinations;

(4) data collection processes and analytical methods used to assess utilization of health care services;

(5) provisions to ensure the confidentiality of clinical, proprietary, and protected health information;

(6) the health care insurer's organizational mechanism, such as a utilization review committee or quality assurance or other committee, that periodically assesses the health care insurer's utilization review program and reports to the health care insurer's governing body; and

(7) the position title health for the care insurer's staff member that is responsible for the day-to-day management of the utilization review program. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.908. Operational requirements. (a) A utilization review program must use documented clinical review criteria that are

(1) based on sound clinical evidence; and

(2) evaluated periodically by a health care insurer's organizational mechanism specified under 3 AAC 28.906(b)(6) to ensure the program's effectiveness.

(b) A health care insurer may develop its own clinical review criteria or obtain clinical review criteria from qualified vendors. A health care insurer shall make its clinical review criteria available upon request to government agencies authorized by the director or by law to receive the information.

(c) Qualified health care professionals must administer the utilization review program and oversee utilization review decisions. A clinical peer must evaluate the clinical appropriateness of adverse determinations.

(d) A health care insurer shall issue a utilization review and benefit determination in a timely manner under 3 AAC 28.910 and 3 AAC 28.912.

(e) A covered person shall be considered to have exhausted the provisions of 3 AAC 28.900 – 3 AAC 28.918 if a health care insurer fails to adhere to the requirements under 3 AAC 28.910 or 3 AAC 28.912 and may

(1) file a request for external review under 3 AAC 28.950 – 3 AAC 28.982; and

(2) pursue an available remedy under state or federal law on the basis that the health care insurer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(f) Notwithstanding (e) of this section, a covered person shall not be considered to have exhausted the provisions of 3 AAC 28.910 – 3 AAC 28.912 if the failure of a health care insurer to adhere to the requirements of 3 AAC 28.910 or 3 AAC 28.912 is a de minimis violation that

(1) does not cause, and is not likely to cause, prejudice or harm to the covered person;

(2) the health care insurer demonstrates was for good cause or due to matters beyond the health care insurer's control;

(3) occurred in the context of an ongoing, good faith exchange of information between the health care insurer and the covered person or the covered person's authorized representative; and

(4) is not a part of a pattern or practice of violations by the health care insurer.

(g) A covered person or the covered person's authorized representative may request a written explanation of a de minimis violation from a health care insurer. Not later than 10 days after receiving a request, the health care insurer shall

(1) provide a written explanation of the alleged violation; and

(2) the specific reasons for asserting that the violation is de minimis.

(h) A covered person or the covered person's authorized representative may resubmit and pursue a review of a benefit request or claim under 3 AAC 28.900 – 3 AAC 28.918 or file a grievance under 3 AAC 28.930 – 3 AAC 28.938 if an independent reviewer or a superior court rejects the benefit request or claim for immediate review on the basis that the violation is a de minimis violation under (f) of this section. The time period for re-filing the benefit request or claim under (h) of this section begins to run when the covered person or the covered person's authorized representative receives notice of the opportunity to resubmit.

(i) Not later than 10 days after receiving notice from an independent reviewer or a superior court of its rejection of a benefit request or claim for immediate review, a health care insurer shall provide to the covered person or the covered person's authorized representative

notice of the opportunity to resubmit and, as applicable, pursue a review of the benefit request or claim under 3 AAC 28.900 – 3 AAC 28.918.

(j) A health care insurer shall

(1) have procedures in place to ensure the

(A) health care professionals administering the health care insurer's utilization review program are applying the clinical review criteria consistently in review determinations; and

(B) appropriate or required individual or individuals are designated to conduct utilization reviews;

(2) routinely assess the effectiveness and efficiency of its utilization review program;

(3) have data systems sufficient to

(A) support utilization review program activities; and

(B) generate management reports to enable the health care insurer to monitor and manage health care services effectively;

(4) maintain adequate oversight over utilization review activity delegated to a utilization company, which must include

(A) a written description of the utilization review company's activities and responsibilities, including the company's reporting requirements;

(B) evidence of the health care insurer's formal approval of the utilization review company’s program; and

(C) a process by which the health care insurer shall evaluate the utilization review company's performance;

(5) coordinate the utilization review program with other medical management activity conducted by the health care insurer, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management;

(6) provide covered persons and participating providers with access to the health care insurer's utilization review staff through a toll-free telephone number or other free calling option, and by electronic means; and

(7) when conducting a utilization review,

(A) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination; and

(B) ensure the independence and impartiality of each individual involved in making the utilization review or benefit determination.

(k) A health care insurer may not base the following decisions related to an individual involved in making a utilization review or benefit determination on the likelihood that the individual will support the denial of benefits:

(1) hiring;

(2) compensation;

(3) termination;

(4) promotion; or

(5) other similar matter. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.910. Procedures for standard utilization review and benefit determinations. (a) A health care insurer shall establish and maintain written procedures for

(1) receiving a benefit request from a covered person or the covered person's representative;

(2) making a standard utilization review and benefit determination; and

(3) notifying a covered person or their authorized representative of the health care insurer's determination not later than the specified time frames required under this section.

(b) For a prospective review determination, a health care insurer shall make the determination and notify the covered person or the covered person's authorized representative of the determination, whether the health care insurer certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but not later than five working days after the date the health care insurer receives the request. If the determination is an adverse determination, the health care insurer shall make the notification of the adverse determination under (n) – (t) of this section.

(c) The time period for making a determination and notifying the covered person or the covered person's authorized representative under (b) of this section may be extended one time by a health care insurer for not later than five working days, provided the health care insurer

(1) determines an extension is necessary due to matters beyond the health care insurer's control; and

(2) notifies the covered person or the covered person's authorized representative, before the expiration of the initial five working day time period, of

(A) the circumstances requiring the extension of time; and

(B) the date by which the health care insurer expects to make a determination.

(d) If the extension under (c) of this section is due to the failure of the covered person or the covered person's authorized representative to submit the information necessary to reach a determination on the request, the notice of extension must

(1) specifically describe the required information necessary to complete the request; and

(2) give the covered person or the covered person's authorized representative not less than 45 days from the date of receipt of the notice of extension to provide the specified information.

(e) After receiving from a covered person or a covered person's authorized representative a prospective review request that fails to meet the health care insurer's filing procedures, a health care insurer shall notify the covered person or the covered person's authorized representative as soon as possible, but not later than five working days

(1) of the failure to meet the health care insurer's filing procedures; and

(2) provide the proper procedures for filing a request.

(f) A health care insurer may provide the notice under (e) of this section orally or, if requested by the covered person or the covered person's authorized representative, in writing.

(g) The provisions of (e) and (f) of this section shall apply only if the failure is a communication

(1) by a covered person or a covered person's authorized representative that is received by a person or organizational unit of a health care insurer responsible for handling benefit matters; and

(2) that refers to a specific

(A) covered person;

(B) medical condition or symptom; and

(C) health care service, treatment, or provider for which certification is being requested.

(h) For a concurrent review determination, if a health care insurer has certified an ongoing course of treatment to be provided over a period of time or number of treatments

(1) a benefit reduction or termination by the health care insurer during the course of treatment before the end of the period or number of treatments, other than by health care insurance policy amendment or termination of the health care insurance policy, shall constitute an adverse determination;

(2) the health care insurer shall notify the covered person or the covered person's authorized representative under (n) – (t) of this section sufficiently in advance of the benefit

reduction or termination to allow the covered person or the covered person's authorized representative

(A) to file a grievance to request a review of the adverse determination under 3 AAC 28.930 – 3 AAC 28.938; and

(B) obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated; and

(3) the health care insurer shall continue without liability to the covered person, with respect to the internal review request made under 3 AAC 28.930 – 3 AAC 28.938, the health care service or treatment that is the subject of the adverse determination.

(i) For a retrospective review determination, a health care insurer shall make the determination within a reasonable period of time, but not later than 30 days after receiving the benefit request. If the determination is an adverse determination, a health care insurer shall provide the notice of the adverse determination to the covered person or the covered person's authorized representative under (n) – (t) of this section.

(j) The time period for making a determination and notifying the covered person or the covered person's authorized representative under (i) of this section may be extended one time by a health care insurer for not later than 15 days provided the health care insurer

(1) documents an extension is necessary due to matters beyond the health care insurer's control; and

(2) notifies the covered person or the covered person's authorized representative, before the expiration of the initial 30 day time period, of

(A) the circumstances requiring the extension of time; and

(B) the date by which the health care insurer expects to make a determination.

(k) If the extension under (j) of this section is due to the failure of the covered person or the covered person's authorized representative to submit the information necessary to reach a determination on the request, the notice of extension must

(1) specifically describe the required information necessary to complete the request; and

(2) give the covered person or the covered person's authorized representative not less than 45 days from the date of receipt of the notice of extension to provide the specified information.

(*l*) The time period within which a determination is required to be made under (b) and (i) of this section begins on the date the request is filed with a health care insurer under the health care insurer's procedures established under 3 AAC 28.906 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing. If the time period for making the determination under (b) or (i) of this subsection is extended under (c) or (j) of this section, a health care insurer shall not include, in the time period for making the determination, the date on which the health care insurer sends notification of the extension to the covered person or the covered person's authorized representative until the earlier of the date on which the

(1) covered person or the covered person's authorized representative responds to the request for additional information; or

(2) specified information was to have been submitted.

(m) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension under (d) or (k) of this section, a health care insurer may deny the certification of the requested benefit.

(n) A notification of an adverse determination under this section must be set out in a manner calculated to be understood by a person who has an average knowledge of health and medicine and must include

(1) information sufficient to identify the benefit request or claim involved, including, if applicable, the date of service, the health care provider, and, if applicable, the claim amount;

(2) a statement describing

(A) the diagnosis code and the code's corresponding meaning; and

(B) the treatment code and the code's corresponding meaning;

(3) the specific reason or reasons for the adverse determination, including

(A) the denial code and code's corresponding meaning; and

(B) a description of the health care insurer's standard, if any, used in denying the benefit request or claim;

(4) reference to the specific plan provisions on which the determination is based;

(5) a description of additional material or information necessary for the covered person or the covered person's authorized representative to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(6) a description of the health care insurer's grievance procedures established under 3 AAC 28.930 – 3 AAC 28.938, including time limits, if any, applicable to those procedures;

(7) if the health care insurer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination,

(A) the specific rule, guideline, protocol, or other similar criterion; or

(B) a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person or the covered person's authorized representative upon request;

(8) if the adverse determination is based on a medical necessity or experimental or investigational treatment, or similar exclusion or limit

(A) an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health care insurance policy to the covered person's medical circumstances; or

(B) a statement that an explanation will be provided free of charge to the covered person or the covered person's authorized representative upon request;

(9) if applicable, instructions for requesting

(A) a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination under (7) of this subsection; or

(B) the written statement of the scientific or clinical rationale for the determination under (8) of this subsection; and

(10) a statement explaining the availability of, and the right of, the covered person or the covered person's authorized representative to

(A) contact the division for assistance; the statement must include the division's current mailing address, electronic mail address, and telephone number; or

(B) upon completion of a health care insurer's grievance procedure process under 3 AAC 28.930 – 3 AAC 28.938, file a civil suit in superior court.

(o) A health care insurer shall provide the notice required under (n) of this section in a culturally and linguistically appropriate manner under whichever of the following federal regulations is applicable to the health care insurer's notice:

(1) 29 C.F.R. 2590.715-2719(e) as revised as of November 18, 2015, and adopted by reference;

(2) 45 C.F.R. 147.136(e) as revised as of November 18, 2015, and adopted by reference;

(p) To meet the requirements of (o) of this section, a health care insurer shall

(1) provide oral language services, such as a telephone assistance hotline, that include, in the applicable non-English language,

(A) answering questions; and

(B) providing assistance with filing

(i) benefit requests;

(ii) claims; and

(iii) appeals;

(2) provide, upon request, a notice in the applicable non-English language; and

(3) include in the English version of all notices, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the health care insurer.

(q) For purposes of (p) of this section, with respect to a borough equivalent to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the borough equivalent is literate only in the same non-English language, as determined in *CLAS County Data, Edition Date: January 2016*, issued by the federal Department of Health and Human Services, Centers for Medicare & Medicaid Services, on January 27, 2016, and adopted by reference.

(r) A health care insurer offering group or individual health insurance coverage may not rescind coverage under the health care insurance policy, certificate of coverage, or contract of insurance, with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, once the individual is covered under the plan or coverage, unless the individual or person seeking coverage on behalf of the individual

(1) performs an act, practice, or omission that constitutes fraud; or

(2) makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage; a health care insurer must provide not less than 30 days advance written notice to each participant, including a primary subscriber in the individual market, who would be affected before coverage may be rescinded.

(s) If the adverse decision is a rescission, a health care insurer shall provide in the advance notice of the rescission determination required under (r) of this section, in addition to the applicable disclosures required under (n) of this section,

(1) a clear identification of the

(A) alleged fraudulent act, practice, or omission; or

(B) intentional misrepresentation of material fact;

(2) an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) notice that the covered person or the covered person's authorized representative, before the date of the advance notice of the proposed rescission ends, may immediately file a grievance under 3 AAC 28.930 – 3 AAC 28.938 to request a review of the adverse determination to rescind coverage;

(4) a description of the health care insurer's grievance procedures established under 3 AAC 28.930 – 3 AAC 28.938, including time limits, if any, applicable to those procedures; and

(5) the date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

(t) A health care insurer may provide a notice required under this section in writing, by electronic mail, or orally. If the notice of the adverse determination is provided orally, the health care insurer shall provide written or electronic mail notice of the adverse decision not later than three days following the oral notification. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

Editor's note: *CLAS County Data, Edition Date: January 2016*, issued by the federal Department of Health and Human Services, Centers for Medicare & Medicaid Services, on January 27, 2016, may be obtained from the Centers for Medicare & Medicaid Services website at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf, the Alaska Division of Insurance website at https://www.commerce.alaska.gov/web/ins/, or by writing to the Alaska Division of Insurance, P.O. Box 110805, Juneau, AK 99801-0805, or by contracting the division at insurance@alaska.gov.

3 AAC 28.912. Procedures for expedited utilization review and benefit determinations. (a) A health care insurer shall establish and maintain written procedures for

(1) receiving a benefit request from a covered person or the covered person's authorized representative;

(2) making an expedited utilization review and benefit determination with respect to

(A) an urgent care request; and

(B) a concurrent review urgent care request; and

(3) notifying a covered person or their authorized representative of the health care insurer's determination not later than the specified time frames under this section.

(b) The written procedures under (a) of this section must provide that, if a covered person or the covered person's authorized representative fails to follow the health care insurer's procedures for filing an urgent care request, the health care insurer shall notify the covered person or the covered person's authorized representative of the failure and the proper procedures to follow for filing the request. A health care insurer shall provide the notice in this subsection to the covered person or the covered person's authorized representative as soon as possible, but not later than 24 hours after receipt of the request. A health care insurer may provide the notice orally, unless the covered person or the covered person's authorized representative requests the notice to be in writing.

(c) The provisions of (b) of this section shall apply only if the failure is a communication

(1) by a covered person or a covered person's authorized representative that is received by a person or organizational unit of the health care insurer responsible for handling benefit matters; and

(2) that refers to a specific

(A) covered person;

(B) medical condition or symptom; and

(C) health care service, treatment, or provider for which approval is requested.

(d) Except under (e) of this section, for an urgent care request, a health care insurer shall notify the covered person or the covered person's authorized representative of the health care insurer's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible taking into account the medical condition of the covered person, but not later than 24 hours after the receipt of the request by the health care insurer. If a health care insurer's determination is an adverse determination, the health care insurer shall provide notice of the adverse determination under (*l*) of this section.

(e) For an urgent care request, if a covered person or the covered person's authorized representative fails to provide sufficient information for a health care insurer to make a determination, the health care insurer shall notify the covered person or the covered person's authorized representative, orally or, if requested by the covered person or the covered person's authorized representative, in writing, of the failure and state what specific information is needed. The health care insurer shall provide the notice as soon as possible, but not later than 24 hours after receipt of the request.

(f) A health care insurer shall provide a covered person or the covered person's authorized representative a reasonable period of time to submit the specified information, taking into account the circumstances, but not less than 48 hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information under (e) of this section.

(g) A health care insurer shall notify a covered person or the covered person's authorized representative of the health care insurer's determination with respect to the urgent care request as soon as possible, but not later than 48 hours after the earlier of

(1) the health care insurer's receipt of the requested specified information; or

(2) the end of the period provided for the covered person or the covered person's authorized representative to submit the requested specified information.

(h) If a covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in (f) of this section, a health care insurer may deny the certification of the requested benefit.

(i) If a health care insurer's determination of an urgent care request is an adverse determination, a health care insurer shall provide notice of the adverse determination under (*l*) of this section.

(j) For a concurrent review urgent care request involving a request by a covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made 24 hours before the expiration of the prescribed period of time or number of treatments, a health care insurer shall make a determination, whether the determination is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but not later than 24 hours after the health care insurer's receipt of the request. If the health care insurer's determination is an adverse determination, the health care insurer shall provide notice of the adverse determination under (*l*) of this section.

(k) The time period within which a determination is required to be made under this section begins on the date the request is filed with a health care insurer under the health care insurer's procedures established under 3 AAC 28.906 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(*l*) The requirements under 3 AAC 28.910(n) – (t) for a standard utilization review and benefit determination apply to an expedited review and benefit determination. An expedited review and benefit determination notification of an adverse determination must include a description of a health care insurer's expedited review procedures established under 3 AAC 28.938. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.914. Emergency services. (a) A health care insurer shall follow the provisions of this section when conducting a utilization review or making a benefit determination for emergency services.

(b) A health care insurer shall cover emergency services to screen and stabilize a covered person

(1) without the need for prior authorization of emergency services if a prudent person would reasonably believe that an emergency medical condition exists even if the emergency services are provided on an out-of-network basis;

(2) without regard to whether the health care provider furnishing the services is a participating provider with respect to the services;

(3) if the emergency services are provided out-of-network, without imposing an administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(4) if the emergency services are provided out-of-network, by complying with the cost-sharing requirements of (d) – (h) of this section; and

(5) without regard to another term or condition of coverage, other than

(A) the exclusion of, or coordination of, benefits;

(B) an affiliation or waiting period permitted under 42 U.S.C. 300gg-19a; or

(C) applicable cost-sharing, under (c) or (d) – (h) of this section.

(c) For in-network emergency services, coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

(d) Except under (e) of this section, for out-of-network emergency services, a cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person may not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

(e) A covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount a health care insurer is required to pay under (d) of this subsection.

(f) A health care insurer complies with the requirements of (d) and (e) of this section by paying for emergency services provided by an out-of-network provider in an amount not less

than the greatest of the following, taking into account the exceptions under (g) and (h) of this section:

(1) the amount negotiated with in-network providers for emergency services, excluding an in-network copayment or coinsurance imposed with respect to the covered person;

(2) the amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(3) the amount that would be paid under Medicare for the emergency services, excluding an in-network copayment or coinsurance requirements.

(g) For capitated or other health care insurance policies that do not have a negotiated charge for each service for in-network providers, (f)(1) of this section does not apply.

(h) If a health plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in (f)(1) of this section is the median of those negotiated amounts.

(i) A health care insurer may impose only in-network cost-sharing amounts on out-of-network emergency services.

(j) If prior authorization is required for a post-evaluation or post-stabilization services review, a health care insurer shall provide access to a designated representative 24 hours a day, seven days a week, to facilitate the review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.916. Confidentiality requirements. A health care insurer shall annually certify in writing to the director that the utilization review program of the health care insurer or the health care insurer's designee complies with all applicable state and federal laws that establish confidentiality and reporting requirements. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.918. Disclosure requirements. (a) A health care insurer shall set out in, or attach to, a policy, certificate of coverage, membership booklet, or other evidence of coverage provided to a covered person by a health care insurer a clear and comprehensive description of the health care insurer's utilization review procedures. The description must include

(1) the procedures for obtaining review of an adverse determination; and

(2) a statement of rights and responsibilities of a covered person with respect to those procedures.

(b) A health care insurer shall include a summary of the health care insurer's utilization review and benefit determination procedures in the materials intended for a prospective covered person.

(c) A health care insurer's membership card must include a toll-free telephone number a covered person or the covered person's authorized representative may call for a utilization review and benefit decision. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

Article 11. Health Care Insurer Grievance Procedures.

Section

3 AAC 28.930. Applicability. Except as otherwise provided, 3 AAC 28.930 – 3 AAC 28.938 apply to a health care insurer transacting health care insurance in this state. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.932. Grievance reporting; recordkeeping requirements. (a) A health care insurer shall maintain a written calendar year register, in a manner that is reasonably clear and accessible to the director, to document

(1) each grievance received;

(2) a general description of the reason for the grievance;

(3) the date the grievance was received;

(4) the date of each review;

(5) resolution of the grievance;

(6) date of resolution;

(7) name of the covered person for whom the grievance was filed;

(8) the health care insurer's review of each grievance;

(9) notices and claims associated with each grievance;

(10) each request for a review of a grievance involving an adverse determination;

(11) evidence sufficient to document compliance with this section;

(b) A health care insurer shall make the records maintained under (a) of this section available to the following upon request:

(1) covered person or the covered person's authorized representative;

(2) the director;

(3) applicable federal oversight agency.

(c) Except under (d) of this section, a health care insurer shall retain a calendar year register for the longer of

(1) three years; or

(2) until the director has adopted a final report of an examination that contains a review of the register for that calendar year.

(d) Notwithstanding (c) of this section, a health care insurer shall retain calendar year register records of a claim filed, and notice provided, under 3 AAC 28.936(o) and 3 AAC 28.938(h) for six years.

(e) A health care insurer shall submit to the director a calendar year annual report in a format approved by the director. The report must include for each type of health care insurance policy offered by the health care insurer

(1) a certificate of compliance stating the health care insurer has established and maintains, for each health care insurance policy, grievance procedures that fully comply with 3 AAC 28.930 – 3 AAC 28.938;

(2) the number of covered lives;

(3) the total number of grievances;

(4) the number of grievances resolved and their resolution;

(5) the number of grievances appealed to the director of which the health care insurer is aware;

(6) the number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(7) a synopsis of actions being taken by the health care insurer to correct problems identified by the health care insurer or the division during a grievance. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.934. Grievance review procedures. (a) Except under 3 AAC 28.938, a health care insurer shall use written procedures for receiving and resolving a grievance under 3 AAC 28.930 – 3 AAC 28.938.

(b) A covered person will be considered to have exhausted the provisions of 3 AAC 28.930 – 3 AAC 28.938 if a health care insurer fails to adhere to the requirements of 3 AAC 28.936 or 3 AAC 28.938 and may

(1) file a request for external review under 3 AAC 28.950 – 3 AAC 28.982; and

(2) pursue an available remedy under state or federal law on the basis that the health care insurer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(c) Notwithstanding (b) of this section, a covered person is considered not to have exhausted the provisions of 3 AAC 28.930 – 3 AAC 28.938 if the failure of a health care insurer to adhere to the requirements of 3 AAC 28.936 or 3 AAC 28.938 is

(1) a de minimis violation that

(A) does not cause, and is not likely to cause, prejudice or harm to the covered person;

(B) the health care insurer demonstrates was for good cause or due to matters beyond the health care insurer's control;

(C) occurred in the context of an ongoing, good faith exchange of information between the health care insurer and the covered person or the covered person's authorized representative; and

(D) is not a part of a pattern or practice of violations by the health care insurer.

(d) A covered person or the covered person's authorized representative may request a written explanation of the de minimis violation from a health care insurer. Not later than 10 days after receiving the request, the health care insurer shall

(1) provide a written explanation of the alleged violation; and

(2) the specific reasons for asserting that the violation is de minimis.

(e) A covered person or the covered person's authorized representative may resubmit and pursue a review of a grievance under 3 AAC 28.930 – 3 AAC 28.938 if an independent reviewer or superior court rejects the grievance involving an adverse determination for immediate review on the basis that the violation is a de minimis violation under (c) of this section.

(f) Not later than 10 days after receiving notice from an independent reviewer or a court of a rejection of a grievance due to a de minimis violation, a health care insurer shall provide to a covered person or the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under 3 AAC 28.930 – 3 AAC 28.938. The time period for re-filing the benefit request or claim under (e) of this section begins to run when the covered person or the covered person's authorized representative receives notice of the opportunity to resubmit.

(g) A health care insurer shall file with the director

(1) a copy of the grievance procedures required under this section including all forms used to process requests under 3 AAC 28.936; and

(2) subsequent material modifications to previously filed documents.

(h) The director may disapprove a filing received under (g) of this section that fails to comply with the provisions of 3 AAC 28.930 – 3 AAC 28.938.

(i) A health care insurer shall set out in, or attach to, a policy, certificate of coverage, membership booklet, outline of coverage, or other evidence of coverage provided to a covered person, a description of the grievance procedures required under 3 AAC 28.930 – 3 AAC 28.938. The description and other grievance procedure documents of the health care insurer must include

(1) a statement of a covered person's or the covered person's authorized representative's right to contact the director for assistance at any time; the statement must include the division's current mailing address, electronic mail address, and telephone number. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.936. Reviews of grievances involving an adverse determination. (a) A covered person or the covered person's authorized representative may file a grievance with a health care insurer requesting a review of an adverse determination. The covered person or the cover person's authorized representative shall file the request not later than 180 days after the covered person or the covered person's authorized representative received notice of the adverse determination under 3 AAC 28.900 – 3 AAC 28.918. The health care insurer shall extend the 180 day time period for filing a request if the

(1) covered person or the covered person's authorized representative files a request with the health care insurer seeking an extension; and

(2) the written request for the extension sets out one or more justifications for the extension that a prudent person would consider to be a fair and reasonable basis for allowing the extension; the covered person or the covered person's authorized representative does not need to file the request for an extension under this subsection within the 180 day filing period.

(b) Upon receipt of the grievance filed under (a) of this section, a health care insurer shall provide to the covered person or the covered person's authorized representative the name, address, and telephone number of the person or organizational unit designated by the health care insurer to coordinate the review on behalf of the health care insurer.

(c) For a review conducted under this section, a health care insurer shall ensure the independence and impartiality of each individual involved in making the review decision.

(d) A health care insurer may not base the following decisions related to an individual involved in making a review decision on the likelihood that the individual will support the denial of benefits:

(1) hiring;

(2) compensation;

(3) termination;

(4) promotion; or

(5) other similar matter.

(e) In an adverse determination involving utilization review, a health care insurer shall designate an appropriate clinical peer or peers, of the same or similar specialty as would typically

manage the case being reviewed, to review the adverse determination. A health care insurer may not designate a person involved in the initial adverse determination to be a clinical peer.

(f) If more than one clinical peer is designated under (e) of this section, a health care insurer shall ensure that a majority of those designated are health care professionals who have appropriate expertise.

(g) In conducting a review under this section, a reviewer shall consider all comments, documents, records, and other information regarding the request for services submitted by a covered person or the covered person's authorized representative without regard to whether the information was submitted or considered in making the initial adverse determination.

(h) A covered person or the covered person's authorized representative

(1) does not have the right to attend the review;

(2) may submit written comments, documents, records, and other materials relating to the request for benefits for consideration during the review; and

(3) may receive from a health care insurer, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's request for benefits; in this paragraph, "relevant" means a document, record, or other information that

(A) was relied upon in making the benefit determination;

(B) was submitted, considered, or generated in the course of making the adverse determination without regard to whether the document, record, or other information was relied upon in making the benefit determination;

(C) demonstrates that, in making the benefit determination, the health care insurer or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(D) constitutes a statement of policy or guidance with respect to the health care insurance policy concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

(i) Not later than three working days after receiving a grievance, a health care insurer shall provide a covered person or the covered person's authorized representative with notice of the provisions of this section.

(j) The time period within which a decision is required to be made and notice provided under (k) and (*l*) of this section begins on the date the grievance is filed with a health care insurer under the health care insurer's procedures established under 3 AAC 28.934 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing. A health care insurer shall notify and issue a decision in writing or by electronic mail to the covered person or the covered person's authorized representative not later than the time frames required under (k) or (*l*) of this section.

(k) With respect to a grievance of an adverse determination involving a prospective review request, a health care insurer shall notify, and issue a decision to, the covered person or the covered person's authorized representative within a reasonable period of time that is

appropriate given the covered person's medical condition, but not later than 30 days after the date the health care insurer received the grievance under (a) of this section.

(*l*) With respect to a grievance requesting a review of an adverse determination involving a retrospective review request, a health care insurer shall notify, and issue a decision to, the covered person or the covered person's authorized representative within a reasonable period of time but not later than 30 days after the date the health care insurer received the grievance requesting the review made under (a) of this section.

(m) Before issuing a decision under (k) or (*l*) of this section, a health care insurer shall provide free of charge to the covered person or the covered person's authorized representative new or additional evidence relied upon in connection with the grievance, sufficiently in advance of the date the decision is required to be provided, to permit a covered person or the covered person's authorized representative a reasonable opportunity to respond before that date.

(n) Before issuing or providing notice of a final adverse determination under (k) or (*l*) of this section that is based on new or additional rationale, a health care insurer shall provide the new or additional rationale to the covered person or the covered person's authorized representative free of charge and as soon as possible, sufficiently in advance of the date the notice of final adverse determination is to be provided, to permit a covered person or the covered person's authorized representative a reasonable opportunity to respond before that date.

(o) Notice of a decision issued under (k) or (*l*) of this section must be set out in a manner calculated to be understood by a person who has an average knowledge of health and medicine and must include:

(1) the name, title, and qualifying credentials of each person participating as a reviewer in the review process;

(2) information sufficient to identify the claim involved with respect to the grievance, including the date of service, if applicable, the health care provider, and, if applicable, the claim amount;

(3) a statement describing the

(A) diagnosis code and the code's corresponding meaning; and

(B) treatment code and the code's corresponding meaning;

(4) a statement of the reviewers' understanding of the covered person's grievance;

(5) the reviewers' decision which must include

(A) clear terms;

(B) the contract basis or medical rationale in sufficient detail for a covered person or the covered person's authorized representative to respond further to the health care insurer's position;

(6) a reference to the evidence or documentation used as the basis for the decision;

(7) if the decision issued under (k) or (*l*) of this section upholds the adverse determination, the notice must include

(A) the specific reason or reasons for the final adverse determination including:

(i) the denial code and the code's corresponding meaning; and

(ii) a description of the health care insurer's standard, if any, used in reaching the denial;

(B) reference to the specific plan provisions on which the determination is based:

(C) a statement that a covered person or the covered person's authorized representative is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's benefit request; in this subparagraph, "relevant" has the meaning given in (h)(3) of this section;

(D) if a health care insurer relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination,

(i) the specific rule, guideline, protocol, or other similar criterion; or

(ii) a statement that a copy of the rule, guideline, protocol, or other similar criterion was relied upon to make the final adverse determination and a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person or the covered person's authorized representative upon request;

(E) if a final adverse determination is based on a medical necessity or experimental or investigational treatment, or similar exclusion or limit,

(i) an explanation of the scientific or clinical judgment for making the determination which applies the terms of the health care insurance policy to the covered person's medical circumstances; or

(ii) a statement that an explanation will be provided free of charge to the covered person or the covered person's authorized representative upon request;

(F) if applicable, instructions for requesting

(i) a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the final adverse determination under (D) of this paragraph; and

(ii) the written statement of the scientific or clinical rationale for the determination under (E) of this paragraph;

(G) a statement describing the procedures for obtaining an independent external review of the adverse determination under 3 AAC 28.950 – 3 AAC 28.982;

(H) a statement indicating a covered person's right to bring a civil action in superior court;

(I) a statement of a covered person’s or covered person’s authorized representative’s right to contact the director's office for assistance with respect to a claim, grievance, or appeal at any time; the statement must include the division's current mailing address, electronic mail address, and telephone number.

(p) A health care insurer shall provide the notice required under (o) of this section in a culturally and linguistically appropriate manner under whichever of the following federal regulations is applicable to the health care insurer's notice:

(1) 29 C.F.R. 2590.715-2719(e) as revised as of November 18, 2015, and adopted by reference;

(2) 45 C.F.R. 147.136(e) as revised as of November 18, 2015, and adopted by reference;

(q) To meet the requirements of (p) of this section, a health care insurer shall

(1) provide oral language services, such as a telephone assistance hotline, that include, in the applicable non-English language,

(A) answering questions; and

(B) providing assistance with filing

(i) benefit requests;

(ii) claims; and

(iii) appeals;

(2) provide, upon request, a notice in the applicable non-English language; and

(3) include in the English version of all notices, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the health care insurer. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.938. Expedited reviews of grievances involving an adverse determination. (a) A health care insurer shall establish written procedures for the expedited review of an urgent care request of a grievance involving an adverse determination. The procedures must allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

(b) In addition to (a) of this section, a health care insurer shall provide expedited review of a grievance involving an adverse determination with respect to a concurrent review urgent care request involving

(1) an admission;

(2) availability of care;

(3) a continued stay; or

(4) a health care service for a covered person who has received emergency services but has not been discharged from a facility.

(c) A health care insurer shall appoint an appropriate clinical peer or peers, in the same or similar specialty as would typically manage the case being reviewed, to review the adverse determination. A health care insurer may not designate a person involved in making the initial adverse determination to be a clinical peer.

(d) In an expedited review, a health care insurer shall transmit all necessary information, including the health care insurer's decision, to a covered person or the covered person's authorized representative by telephone, facsimile transmission, electronic mail, or the most expeditious method available.

(e) A health care insurer shall make an expedited review decision and shall notify a covered person or the covered person's authorized representative of the decision under (h) of this section as expeditiously as the covered person's medical condition requires, but not later than 72 hours after the receipt of the request for the expedited review.

(f) If an expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, a health care insurer shall continue coverage of the services without liability to a covered person until the covered person or the covered person's authorized representative is notified of the determination.

(g) The time period within which a decision is required to be made under (e) of this section begins on the date a request is filed with a health care insurer under the health care insurer's procedures established under 3 AAC 28.934 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(h) Except for 3 AAC 28.936(o)(7), the requirements under 3 AAC 28.936(o) – 3 ACC 28.936(q), for the review of a grievance involving an adverse determination, apply to an expedited review of a grievance involving an adverse determination. An expedited review of a grievance involving an adverse determination notice must include a description of additional material or information necessary for a covered person or the covered person's authorized representative to complete a request including an explanation of why the material or information is necessary to complete the request. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

Article 12. External Review of Health Care Coverage Decisions.

Section

3 AAC 28.950. Applicability. (a) Except under (b) of this section, 3 AAC 28.950 – 3 AAC 28.982 apply to a health care insurer that transacts health care insurance in this state.

(b) 3 AAC 28.950 – 3 AAC 28.982 do not apply to:

(1) a policy or certificate that provides coverage only for a specified disease, specified accident, or accident-only coverage, or for credit, disability income, hospital indemnity, long term care insurance defined under AS 21.53.200, vision care, or other limited supplemental benefit;

(2) a Medicare supplement policy of insurance defined under 3 AAC 28.510;

(3) coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program;

(4) coverage issued under 10 U.S.C. 1071 – 1110b, and coverage issued as supplemental to that coverage;

(5) coverage issued as supplemental to liability insurance;

(6) workers' compensation or similar insurance;

(7) automobile medical-payment insurance or insurance under which a benefit is payable without regard to fault, whether written on a group blanket or individual basis. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.952. Notice of right to external review. (a) A health care insurer shall notify a covered person or the covered person's authorized representative in writing of the covered

person's right to request an external review under 3 AAC 28.958 – 3 AAC 28.962. A health care insurer shall provide the notice of the right to request an external review when the health care insurer sends written notice of

(1) an adverse determination upon completion of the health care insurer's utilization review process under 3 AAC 28.900 – 3 ACC 28.918; and

(2) a final adverse determination.

(b) The notice under (a) of this section must include the following, or substantially equivalent, language:

"We have denied your request for the provision of, or payment for, a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us 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 by submitting a request for external review to the director of the Alaska Division of Insurance by mail or personal delivery at the Alaska Division of Insurance, 550 West 7th Avenue, Anchorage, AK. 99501-3567, by electronic mail to insurance@alaska.gov, or by facsimile transmission by calling (907) 269-7910."

(c) A notice under (a) of this section relating to an adverse determination must include a statement informing a covered person or the covered person's authorized representative that if the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination under 3 AAC 28.938 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may

(1) file a request for an expedited external review under 3 AAC 28.960, or 3 AAC 28.962 if the adverse determination involves a denial of coverage based on a

determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated; and at the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination under 3 AAC 28.938, the independent review organization assigned to conduct the expedited external review shall determine whether the covered person or the covered person's authorized representative shall be required to complete the expedited review of the grievance before conducting the expedited external review; and

(2) file a grievance under the health care insurer's internal grievance process under 3 AAC 28.936; however, the covered person or the covered person's authorized representative may file a request for external review under 3 AAC 28.954 and will be considered to have exhausted the health care insurer's internal grievance process for purposes of 3 AAC 28.956 if

(A) the health care insurer has not issued a written decision to the covered person or the covered person's authorized representative not later than 30 days after the date the covered person or the covered person's authorized representative files the grievance with the health care insurer; and

(B) the covered person or the covered person's authorized representative has not requested or agreed to a delay.

(d) A notice under (a) of this section relating to a final adverse determination must include a statement informing a covered person or the covered person's authorized representative that the covered person or the covered person's authorized representative may request

(1) an expedited external review under 3 AAC 28.960 if

(A) the covered person has a medical condition where the time frame for completion of a standard external review under 3 AAC 28.958 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(B) the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility;

(2) a standard external review under 3 AAC 28.962 if a denial of coverage was based on a determination that the recommended or requested health care service or treatment is experimental or investigational; or

(3) an expedited external review under 3 AAC 28.962 if

(A) a denial of coverage was based on a determination that the recommended or requested health care service or treatment is experimental or investigational; and

(B) the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(e) A health care insurer shall include with a notice under (a) of this section a copy of the description of the standard and expedited external review procedures the health care insurer is required to provide under 3 AAC 28.982; the description must

(1) highlight the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information; and

(2) include the forms the health care insurer uses to process an external review.

(f) A health care insurer shall include with the notice under (a) of this section a release form, or other document approved by the director that complies with the requirements of 45 C.F.R. 164.508, as revised as of January 25, 2013, and adopted by reference, by which the covered person or the covered person's authorized representative authorizes the health care insurer and the covered person's treating health care provider to disclose protected health information, including medical records concerning the covered person that are pertinent to the external review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.954. Request for external review. (a) A covered person or the covered person's authorized representative may make a request to the director for an external review of an adverse determination or a final adverse determination. Except for a request for an expedited external review, a covered person or the covered person’s authorized representative shall submit a request for an external review to the director not later than 180 days after the covered person or

the covered person's authorized representative receives notice of the adverse determination. The director will extend the 180 day time period for filing the request if the

(1) covered person or the covered person's authorized representative files a written request with the director seeking an extension; and

(2) the request for the extension sets out one or more justifications for the extension that a prudent person would consider to be a fair and reasonable basis for allowing the extension; the covered person or the covered person's authorized representative does not need to file the request for an extension under this subsection within the 180 day filing period.

(b) A covered person or the covered person’s authorized representative may submit a written request for an external review to the director by contacting the division by mail, electronic mail, or facsimile transmission. A written request for an external review must include a copy of the health care insurer's written notice containing the adverse determination or final adverse determination.

(c) A covered person or the covered person’s authorized representative may make an oral request to the director for an expedited external review by calling the Alaska Division of Insurance at (907) 269-7900. The director may require submission of additional documents or information including physician certifications or medical information releases considered practicable under the time constraints.

(d) There is no charge for submitting a request for an external review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.956. Exhaustion of internal grievance process. (a) Except as otherwise provided under this section, before making a request for an external review, a covered person or the covered person's authorized representative must exhaust a health care insurer's internal grievance process under 3 AAC 28.930 – 3 AAC 28.938.

(b) A covered person or the covered person's authorized representative will be considered to have exhausted a health care insurer's grievance process if

(1) the covered person or the covered person's authorized representative has filed a grievance involving an adverse determination; and

(2) except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health care insurer not later than 30 days after the covered person or the covered person's authorized representative filed the grievance with the health care insurer.

(c) Notwithstanding (b) of this section, a covered person or the covered person's authorized representative must exhaust a health care insurer's internal grievance process before making a request for an external review of an adverse determination involving a retrospective review determination made under 3 AAC 28.900 – 3 AAC 28.918.

(d) When a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination under 3 AAC 28.938, the covered person or the covered person's authorized representative may file a request

for an expedited external review of an adverse determination without exhausting a health care insurer's internal grievance process if

(1) under 3 AAC 28.960, the covered person has a medical condition where the time frame for completion of an internal review of the grievance involving an adverse determination under 3 AAC 28.938 would

(A) seriously jeopardize the life or health of the covered person; or

(B) jeopardize the covered person's ability to regain maximum function;

or

(2) under 3 AAC 28.962, the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(e) Before conducting an expedited external review, an independent review organization shall determine whether the covered person is first required to complete the expedited grievance review process under 3 AAC 28.938. Upon determining that the covered person has not exhausted internal grievance processes, the independent review organization shall immediately notify the covered person or the covered person's authorized representative of its determination and that the independent review organization will not proceed with the expedited external review

(1) until completion of the expedited grievance review process; and

(2) while the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(f) A covered person or the covered person's authorized representative may request an external review of an adverse determination before the covered person or the covered person's authorized representative has exhausted a health care insurer's internal grievance procedures if the health care insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the health care insurer's internal grievance procedures is waived, the covered person or the covered person's authorized representative may file a written request with the director for a standard external review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.958. Standard external review. (a) A covered person or a covered person's authorized representative may file a request with the director for an external review of a health care insurer's adverse determination or final adverse determination not later than 180 days after

(1) receipt of a notice of an adverse determination or a final adverse determination;

(2) failure of a health care insurer to issue a written decision not later than 30 days after the covered person or the covered person's authorized representative filed a grievance involving an adverse determination under 3 AAC 28.956(b); or

(3) agreement of the health care insurer to waive the requirement that the covered person or the covered person's authorized representative exhaust the health care insurer's internal

grievance procedures before filing a request for external review of an adverse determination under 3 AAC 28.956(f).

(b) The director will extend the 180 day time period for filing the request if the

(1) covered person or the covered person's authorized representative files a request with the director seeking an extension; and

(2) the request for the extension sets out one or more justifications for the extension that a prudent person would consider to be a fair and reasonable basis for allowing the extension; the covered person or the covered person's authorized representative does not need to file the request for an extension under this subsection within the 180 day filing period.

(c) Not later than one working day after receipt of a request for external review under (a) of this section, the director shall send written notice of the request to the health care insurer.

(d) Not later than five working days after receipt of the external review request under (c) of this section, the health care insurer shall complete a preliminary review of the request to determine whether

(1) the individual is or was a covered person under the health care insurance policy when the health care service or treatment was recommended or requested or, if a retrospective review, was a covered person under the health care insurance policy when the health care service or treatment was provided;

(2) the health care service or treatment that is the subject of the adverse determination or final adverse determination is a covered service under the covered person's health care insurance policy but for a determination by the health care insurer that the health care

service or treatment is not covered because the service or treatment does not meet the health care insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(3) the covered person or the covered person's authorized representative has exhausted the health care insurer's internal grievance process, unless the covered person or the covered person's authorized representative is not required to exhaust the health care insurer's internal grievance process under 3 AAC 28.956 or this section; and

(4) the covered person or the covered person's authorized representative has provided all of the information and forms required to process an external review request including the release form under 3 AAC 28.952(f).

(e) Not later than one working day after completion of a preliminary review under (d) of this section, a health care insurer shall notify in writing the covered person or the covered person's authorized representative and the director whether the request is

(1) complete; and

(2) eligible for external review.

(f) If a health care insurer determines the request is not complete, the health care insurer shall notify in writing the covered person or the covered person's authorized representative and the director

(1) that the request is not complete; and

(2) what information or materials are needed to make the request complete.

(g) If a health care insurer determines that a request is not eligible for external review, the health care insurer shall issue a notice of initial determination in writing informing the covered person or the covered person's authorized representative and the director of that determination and the reasons why the request is not eligible for external review. The notice must include a statement that the covered person or the covered person's authorized representative may appeal the health care insurer's initial determination of ineligibility to the director.

(h) Notwithstanding a health care insurer's initial determination that a request is not eligible, the director may determine the request is eligible for external review under (d) of this section and refer the request for external review. The director shall make the determination

(1) under the terms of the covered person's health care insurance policy; and

(2) subject to all applicable provisions under 3 AAC 28.950 – 3 AAC 28.982.

(i) Not later than one working day after receipt of notice of initial determination from a health care insurer that a request for external review is eligible for external review or upon a determination by the director that a request is eligible for external review, the director will

(1) assign an independent review organization to conduct the external review from the list of approved independent review organizations maintained by the director; the director will assign an independent review organization by rotation among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns;

(2) notify the health care insurer of the name of the assigned independent review organization; and

(3) notify the covered person or the covered person's authorized representative in writing

(A) that the request is eligible;

(B) that the request is accepted for external review;

(C) of the name of the assigned independent review organization; and

(D) that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization, not later than five working days after receipt of the notice, additional information that the independent review organization shall consider when conducting the external review; the independent review organization may, in the organization's discretion, accept and consider additional information submitted by the covered person or the covered person's authorized representative later than five working days after receipt of the notice.

(j) Not later than five working days after receipt of a notice of an assignment of an independent review organization, a health care insurer or the health care insurer's designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization. Except under (k) of this section, failure by a health care insurer or the health care insurer's designee utilization review organization to provide the documents and information during the time specified shall not delay the conduct of the external review.

(k) If a health care insurer or health care insurer's designee utilization review organization fails to provide the documents and information during the time specified under (j) of this section, an assigned independent review organization may

(1) terminate the external review; and

(2) make a decision to reverse the adverse determination or final adverse determination; immediately after making the decision, the independent review organization shall notify the covered person or the covered person's authorized representative, the health care insurer, and the director of its decision.

(*l*) An assigned independent review organization shall review the information and documents received under (i)(3)(D) and (j) of this section. The assigned independent review organization shall forward the information and documents to the health care insurer not later than one working day after receipt of the information and documents submitted by the covered person or the covered person's authorized representative.

(m) Upon receipt of the information and documents forwarded to a health care insurer under (*l*) of this section, the health care insurer may reconsider the adverse determination or final adverse determination that is the subject of the external review. The health care insurer's reconsideration of its adverse determination or final adverse determination may not delay or terminate the external review. The external review shall only be terminated if the health care insurer decides, upon completion of the reconsideration, to reverse the health care insurer's determination and provide coverage or payment for the recommended or requested health care

service or treatment that is the subject of the adverse determination or final adverse determination.

(n) Immediately after making a decision to reverse the health care insurer's adverse determination or final adverse determination, a health care insurer shall notify the covered person or the covered person's authorized representative, the assigned independent review organization, and the director in writing of the health care insurer's decision. The assigned independent review organization shall terminate the external review upon receipt of notice of the health care insurer's decision to reverse the health care insurer's adverse determination or final adverse determination.

(o) In addition to the documents and information provided to an assigned independent review organization under (j) of this section, the independent review organization shall, to the extent the information or documents are available and the independent review organization considers them appropriate, consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the attending physician or health care professional's recommendation or request;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health care insurer, covered person, covered person's authorized representative, or the covered person's treating physician or other health care professional;

(4) the terms of coverage under the covered person's health care insurance policy with the health care insurer to ensure that the independent review organization decision is not

contrary to the terms of coverage under the covered person's health care insurance policy with the health care insurer;

(5) the most appropriate practice guidelines that

(A) must include applicable evidence-based standards; and

(B) may include other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) the applicable clinical review criteria developed and used by the health care insurer or the health care insurer's designee utilization review organization; and

(7) the opinion of the independent review organization's clinical reviewer after considering the information or documents described in (1) – (6) of this subsection to the extent the information or documents are available and the clinical reviewer considers them appropriate.

(p) Not later than 45 days after receipt of the request for an external review, an assigned independent review organization shall provide written notice of the independent review organization's decision to uphold or reverse the adverse determination or the final adverse determination of a health care insurer to the covered person or the covered person's authorized representative, the health care insurer, and the director. In reaching a decision, the assigned independent review organization is not bound by a decision or conclusion reached during the health care insurer's utilization review or internal grievance processes. The notice under this subsection must include

(1) a general description of the reason for the request for external review;

(2) the date the independent review organization received the assignment from the director to conduct the external review;

(3) the date the external review was conducted;

(4) the date of the independent review organization's decision;

(5) the principal reason or reasons for the independent review organization's decision, including what applicable evidence-based standards, if any, were a basis for the decision;

(6) the rationale for the decision;

(7) references to evidence or documentation, including evidence-based standards, considered in reaching the decision; and

(8) the professional licenses held by each reviewer.

(q) Upon receipt of notice of a decision of the independent review organization reversing the adverse determination or final adverse determination of the health care insurer under (p) of this section, the health care insurer shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.960. Expedited external review. (a) Except under (k) of this section, a covered person or the covered person's authorized representative may make an oral or written request to the director for an expedited external review of a health care insurer's adverse

determination or final adverse determination when the covered person or the covered person's authorized representative receives

(1) an adverse determination that

(A) involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) the covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination; or

(2) a final adverse determination that

(A) involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(B) concerns emergency or health care services, for which the covered person has not been discharged from a facility, including

(A) an admission;

(B) availability of care;

(C) a continued stay; or

(D) a health care service or treatment.

(b) Upon receipt of a request for an expedited external review, the director will immediately send written notice of the request to the health care insurer.

(c) Immediately upon receipt of notice of a request for expedited external review under (b) of this section, a health care insurer shall complete a preliminary review of the request to determine whether the request meets the eligibility requirements for external review under 3 AAC 28.958(d). If the health care insurer determines the request is not eligible for external review the health care insurer shall immediately issue a notice of initial determination in writing informing the covered person or the covered person's authorized representative and the director of that determination and the reasons the request is not eligible for external review. The notice must include a statement that the covered person or the covered person's authorized representative may appeal the health care insurer's initial determination of ineligibility to the director.

(d) Notwithstanding a health care insurer's initial determination that a request is not eligible, the director may determine the request is eligible for external review under 3 AAC 28.958(d) and refer the request for external review. The director shall make the determination

(1) under the terms of the covered person's health care insurance policy; and

(2) subject to all applicable provisions under 3 AAC 28.950 – 3 AAC 28.982.

(e) Upon receipt of notice of initial determination from a health care insurer that a request is eligible for expedited external review or upon a determination by the director that a request is eligible for expedited external review, the director will immediately

(1) assign an independent review organization to conduct the expedited external review in the manner set out in 3 AAC 28.958(i)(1); and

(2) notify the health care insurer and the covered person or the covered person's authorized representative of the name of the assigned independent review organization.

(f) Upon receiving notice under (e)(2) of this section, a health care insurer or the health care insurer's designee utilization review organization shall immediately provide or transmit by electronic mail, telephone, facsimile transmission or other available expeditious method, all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

(g) In addition to the documents and information provided to an assigned independent review organization under (f) of this section, the assigned independent review organization shall, to the extent the information or documents are available and the independent review organization considers them appropriate, consider the information and documents set out in 3AAC 28.958(o)(1) – (7).

(h) As expeditiously as the covered person's medical condition or circumstances require, but not later than 72 hours after receipt of an eligible request for expedited external review, an assigned independent review organization shall

(1) make a decision to uphold or reverse the adverse determination or final adverse determination of the health care insurer; in reaching a decision the assigned independent review organization is not bound by the decision or conclusion reached during the health care insurer's utilization review or internal grievance processes; and

(2) notify the covered person or the covered person's authorized representative, the health care insurer, and the director of the decision.

(i) If the notice provided under (h) of this section is not in writing, not later than 48 hours after providing that notice, an assigned independent review organization shall provide written confirmation of the decision to the covered person or the covered person's authorized representative, the health care insurer, and the director that includes the information set out in 3 AAC 28.958(p)(1) – (7).

(j) Upon receipt of notice of a decision of the independent review organization reversing the adverse determination or final adverse determination of the health care insurer under (h) of this section, the health care insurer shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

(k) The director shall reject a request for an expedited external review of a retrospective adverse or final adverse determination. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.962. External review of experimental or investigational treatment adverse determinations. (a) A covered person or the covered person's authorized representative may file a request with the director for an external review not later than 180 days after receipt of a health care insurer's notice of adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment

recommended or requested is experimental or investigational. The director will extend the 180 day time period for filing the request if the

(1) covered person or the covered person's authorized representative files a written request with the director seeking an extension; and

(2) the written request for the extension sets out one or more justifications for the extension that a prudent person would consider to be a fair and reasonable basis for allowing the extension; the covered person or the covered person's authorized representative does not need to file the request for an extension under this subsection within the 180 day filing period.

(b) A covered person or the covered person's authorized representative may make an oral or written request to the director for an expedited external review of a health care insurer's adverse determination or final adverse determination if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(c) Upon receipt of a request for an expedited external review, the director will immediately notify the health care insurer of the request.

(d) Immediately upon receipt of notice of a request for an expedited external review under (c) of this section, a health care insurer shall determine whether the request is eligible for external review under (i) of this section. If the health care insurer determines that the request is not eligible for external review, the health care insurer shall immediately issue a notice of initial determination in writing informing the covered person or the covered person's authorized representative and the director of that determination and the reasons the request is not eligible for

review. The notice must include a statement that the covered person or the covered person's authorized representative may appeal the health care insurer's initial determination of ineligibility to the director.

(e) Notwithstanding a health care insurer's initial determination that a request is not eligible, the director may determine the request is eligible for external review under (i) of this section and refer the request for external review. The director shall make the determination

(1) under the terms of the covered person's health care insurance policy; and

(2) subject to all applicable provisions under 3 AAC 28.950 – 3 AAC 28.982.

(f) Upon receipt of the notice of initial determination from a health care insurer that a request is eligible for expedited external review or upon a determination by the director that a request is eligible for expedited external review, the director will immediately

(1) assign an independent review organization to conduct the expedited external review in the manner set out in 3 AAC 28.958(i)(1); and

(2) notify the health care insurer and the covered person or the covered person's authorized representative of the name of the assigned independent review organization.

(g) Upon receiving notice under (f) of this section, a health care insurer or the health care insurer's designee utilization review organization shall immediately provide or transmit by electronic mail, telephone, facsimile transmission, or other available expeditious method, all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

(h) Except for a request for an expedited external review under (b) of this section, not later than one working day after receipt of a request for external review under (a) of this section, the director shall send written notice of the request to the health care insurer.

(i) Not later than five working days after receipt of a notice under (h) of this section, a health care insurer shall complete a preliminary review of the external review request to determine whether

(1) the individual is or was a covered person under the health care insurance policy when the health care service or treatment was recommended or requested or, if a retrospective review, was a covered person in the health care insurance policy when the health care service or treatment was provided;

(2) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination meets the following conditions:

(A) is a covered benefit under the covered person's health care insurance policy except for the health care insurer's determination that the service or treatment is experimental or investigational for a particular medical condition;

(B) is not explicitly listed as an excluded benefit under the covered person's health care insurance policy with the health care insurer;

(3) the covered person's treating physician has certified that one of the following situations is applicable:

(A) standard health care services or treatments have not been effective in improving the condition of the covered person;

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

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

(4) the covered person's treating physician has certified in writing the

(A) recommended or requested health care service or treatment that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person, in the physician's opinion, than other available standard health care services or treatments; or

(B) physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, and scientifically valid studies using accepted protocols demonstrate the health care service or treatment recommended or requested that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than other available standard health care services or treatments;

(5) the covered person or the covered person's authorized representative has exhausted the health care insurer's internal grievance process under 3 AAC 28.930 – 3 AAC

28.938, unless the covered person or the covered person's authorized representative is not required to exhaust the health care insurer's internal grievance process under 3 AAC 28.956; and

(6) the covered person or the covered person's authorized representative has provided the information and forms required to process an external review request including the release form under 3 AAC 28.952(f).

(j) Not later than one working day after completion of a preliminary review under (i) of this section, a health care insurer shall notify the covered person or the covered person's authorized representative and the director in writing whether the request is

(1) complete; and

(2) eligible for external review.

(k) If a health care insurer determines the request is not complete, the health care insurer shall notify the covered person or the covered person's authorized representative and the director in writing

(1) that the request is not complete; and

(2) what information or materials are needed to make the request complete.

(*l*) If a health care insurer determines a request is not eligible for external review, the health care insurer shall issue a notice of initial determination in writing notifying the covered person or the covered person's authorized representative and the director of that determination and the reasons the request is not eligible for external review. The notice must include a statement informing the covered person or the covered person's authorized representative that the health care insurer's initial determination of ineligibility may be appealed to the director;

(m) Notwithstanding a health care insurer's initial determination that a request is not eligible, the director may determine the request is eligible for external review and refer the request for external review. The director shall make the determination

(1) under the terms of the covered person's health care insurance policy; and

(2) subject to all applicable provisions under 3 AAC 28.950 – 3 AAC 28.982.

(n) A health care insurer shall notify the director and the covered person or the covered person's authorized representative if a request for external review is determined eligible for external review.

(o) Not later than one working day after receipt of the notice of initial determination from a health care insurer that a request for external review is eligible for external review or upon a determination by the director that a request is eligible for external review, the director will assign an independent review organization and issue the notification as provided under 3 AAC 28.958(i).

(p) Not later than one working day after receipt of a notice of assignment to conduct an external review under (o) of this section, an assigned independent review organization shall

(1) select one or more clinical reviewers, as the independent review organization determines is appropriate under (q) of this section, to conduct the external review; and

(2) based on the opinion of the clinical reviewer, or opinions if there is more than one clinical reviewer, make a decision to uphold or reverse the adverse determination or final adverse determination.

(q) In selecting clinical reviewers, an assigned independent review organization shall select physicians or other health care professionals who

(1) meet the minimum qualifications described under 3 AAC 28.974; and

(2) through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment that is the subject of the adverse determination or the final adverse determination; a covered person or the covered person's authorized representative or a health care insurer may not choose or control the choice of the clinical reviewers selected to conduct the external review.

(r) Each clinical reviewer selected shall

(1) review all information and documents received and other information submitted in writing by the covered person or the covered person's authorized representative;

(2) review all documents and other information received from the health care insurer under (s) of this section; and

(3) provide a written opinion to the assigned independent review organization regarding whether the recommended or requested health care service or treatment should be covered; in reaching an opinion, a clinical reviewer is not bound by the decision or conclusion reached during the health care insurer's utilization review or internal grievance processes.

(s) Not later than five working days after receipt of the notice of an assignment of an independent review organization, a health care insurer or the health care insurer's designee utilization review organization shall provide or transmit all necessary documents and

information considered in making the adverse determination or the final adverse determination to the assigned independent review organization. Except under (t) of this section, failure by a health care insurer or health care insurer's designee utilization review organization to provide the documents and information during the time specified may not delay the conduct of the external review.

(t) If a health care insurer or health care insurer's designee utilization review organization fails to provide the documents and information during the time specified under (s) of this section, an assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Immediately after making a decision, the independent review organization shall notify the covered person or the covered person's authorized representative, the health care insurer, and the director of the decision.

(u) Not later than one working day after receipt of information and documents submitted by the covered person or the covered person's authorized representative, an assigned independent review organization shall forward the information and documents to the health care insurer.

(v) Upon receipt of the information and documents forwarded to the health care insurer under (u) of this section, the health care insurer may reconsider the adverse determination or final adverse determination that is the subject of the external review. The health care insurer's reconsideration of the adverse determination or final adverse determination may not delay or terminate the external review. The external review shall only be terminated if the health care insurer decides, upon completion of the reconsideration, to reverse the determination and provide

coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(w) Immediately after making a decision to reverse an adverse determination or final adverse determination, a health care insurer shall notify the covered person or the covered person's authorized representative, the assigned independent review organization, and the director in writing of the decision. The assigned independent review organization shall terminate the external review upon receipt of notice of the health care insurer's decision to reverse the adverse determination or final adverse determination.

(x) Except under (y) of this section, not later than 20 days after being selected to conduct an external review, each clinical reviewer shall provide an opinion to the assigned independent review organization regarding whether the recommended or requested health care service or treatment should be covered under this section. Each clinical reviewer's opinion must be in writing and include

(1) a description of the covered person's medical condition;

(2) a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is likely to be more beneficial to the covered person than other available standard health care services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(3) a description and analysis of medical or scientific evidence considered in reaching the opinion;

(4) a description and analysis of applicable evidence-based standards, if any; and

(5) information on whether the reviewer's rationale for the opinion is based on a factor described in (z)(5)(A) or (B) of this section.

(y) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require, but not later than five working days after being selected as a clinical reviewer under (p) of this section. If the opinion provided is not in writing, not later than 48 hours after the opinion is provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include all required information in support of the opinion.

(z) In addition to the documents and information provided under (g) and (s) of this section, each clinical reviewer selected shall, to the extent the information or documents are available and the reviewer considers them appropriate, consider the following in reaching an opinion:

(1) the covered person's pertinent medical records;

(2) the attending physician or health care professional's recommendation or request;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health care insurer, covered person or the covered person's

authorized representative, or the covered person's treating physician or other health care professional;

(4) the terms of coverage under the covered person's health care insurance policy with the health care insurer to ensure that, but for the health care insurer's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health care insurance policy with the health care insurer;

(5) whether either of the following factors is applicable:

(A) the recommended or requested health care service or treatment is approved by the United States Food and Drug Administration, if applicable, for the condition;

(B) medical or scientific evidence or evidence-based standards demonstrate that

(i) the expected benefits of the recommended or requested health care service or treatment is likely to be more beneficial to the covered person than other available standard health care services or treatments; and

(ii) the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(aa) Except under (bb) of this section, not later than 20 days after receipt of the opinion of each clinical reviewer, an assigned independent review organization shall

(1) make a decision based on the opinions of the clinical reviewer or reviewers, to uphold or reverse the adverse determination or final adverse determination of a health care insurer; and

(2) provide written notice of the decision to the covered person or the covered person's representative, the health care insurer, and the director.

(bb) For an expedited external review, not later than 48 hours after receipt of the opinion of each clinical reviewer, an assigned independent review organization shall

(1) make a decision based on the opinions of the clinical reviewer or reviewers to uphold or reverse or the adverse determination or final adverse determination of a health care insurer; and

(2) provide notice of the decision orally or in writing to the covered person or the covered person's authorized representative, the health care insurer, and the director.

(cc) If a notice provided under (bb) of this section is not in writing, not later than 48 hours after providing notice, an assigned independent review organization shall provide written confirmation of the decision to the covered person or the covered person's authorized representative, the health care insurer, and the director.

(dd) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse a health care insurer's adverse determination or final adverse determination.

(ee) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold a health care insurer's adverse determination or final adverse determination.

(ff) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions. The selection of an additional clinical reviewer under this section may not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers for the external review.

(gg) An independent review organization's notice of decision must include

(1) a general description of the reason for the request for external review;

(2) the written opinion of each clinical reviewer which must include

(A) a description of the qualifications of the clinical reviewer;

(B) the recommendation of the clinical reviewer as to whether the recommended or requested health care service or treatment should be covered; and

(C) the rationale for the reviewer's recommendation;

(3) the date the independent review organization received the assignment from the director to conduct the external review;

(4) the date the external review was conducted;

(5) the date of the independent review organization's decision;

(6) the principal reason or reasons for the decision including what applicable evidence-based standards, if any, were a basis for the decision;

(7) the rationale for the decision;

(8) references to the evidence or documentation, including evidence-based standards, considered in reaching the decision; and

(9) the professional licenses held by each reviewer.

(hh) Upon receipt of a notice of a decision of the independent review organization reversing an adverse determination or final adverse determination of a health care insurer under (bb) of this section, a health care insurer shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.964. Declination of external review assignment by the independent review organization. Not later than 24 hours after receipt of an assignment to conduct an external review under 3 AAC 28.958(i)(1), 3 AAC 28.960(e)(1), or 3 AAC 28.962(f)(1), an independent review organization shall

(1) make a determination of the independent review organization's ability to perform the external review; and

(2) advise the director if the independent review organization is unable to perform the review due to

(A) conflict of interest; or

(B) lack of expertise or qualification for the particular subject matter of the review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.966. Binding nature of external review decision. (a) An external review decision is binding on a health care insurer except to the extent the health care insurer has other remedies available under applicable state law.

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

(c) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.968. Term of initial independent review organization registration period; renewal. (a) An initial biennial independent review organization registration period includes the rest of the calendar year in which the registration is issued and all of the following calendar year.

(b) If the director issues an initial biennial independent review organization registration on or after October 1, the registration period includes the rest of the calendar year in which the registration is issued and all of the following two calendar years.

(c) An independent review organization is responsible for knowing the date that the independent review organization's biennial registration period ends and for submitting a renewal independent review organization registration application not later than 30 days before the next biennial registration period begins. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.970. Approval of independent review organizations; registration. (a) The director may assign an independent review organization to conduct an external review in this state if the independent review organization

(1) has an approved registration application on file with the director;

(2) has paid the independent review organization biennial registration fee under 3 AAC 31.060.

(3) is currently in good standing in this state;

(4) is accredited by a nationally recognized private accrediting agency that the director determines has independent review organization accreditation standards that are equivalent or exceed the minimum qualifications for independent review organizations under 3 AAC 28.974; and

(5) meets the minimum qualifications under 3 AAC 28.974.

(b) Notwithstanding (a) of this section, the director may approve an independent review organization that is not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(c) The director shall maintain and periodically update a list of approved independent review organizations. The director will remove an independent review organization from the list if the director determines the independent review organization no longer satisfies the requirements established under this section.

(d) An independent review organization application must include

(1) payment of the biennial independent review organization registration fee under 3 AAC 31.060;

(2) an independent review organization application form prescribed by the director that includes the

(A) name of the state in which the applicant is domiciled;

(B) name of the applicant;

(C) "doing business as" name of the applicant;

(D) complete physical address, mailing address, electronic mail address, telephone number, and facsimile transmission number of the

(i) applicant's principal place of business in the applicant's state of domicile; and

(ii) applicant's principal place of business in this state;

(E) electronic mail address the applicant desires the division to utilize to communicate with the applicant;

(F) internet address of the applicant;

(G) federal employer identification number of the applicant;

(H) the following contact information provided for use on the division's website:

(i) company name;

(ii) contact person for inquiries on external review questions;

(iii) mailing address;

(iv) electronic mail address;

(v) telephone number;

(vi) facsimile transmission number;

(I) the applicant's signed attestation and certification that

(i) verifies the information provided by the applicant is truthful and complete:

(ii) acknowledges that payment of fees associated with external reviews conducted under 3 AAC 28.950 – 3 AAC 28.982 are the sole responsibility of the health care insurer whose covered person's medical condition is being reviewed;

(iii) the applicant has no recourse against the division or the state to the extent that a health care insurer fails to pay fees associated with the external review process; and

(iv) authorizes the director to verify applicant information with a federal, state, or local government agency, insurance company, or accrediting organization;

(J) if applicable, the name and mailing address of the applicant's ultimate controlling owner or holding company; in this subparagraph, "ultimate controlling owner" has the meaning given in 3 AAC 21.195;

(3) a copy of the business license issued to the applicant by the department;

(4) a list of other states in which the applicant is approved to conduct external reviews;

(5) if applicable, a list of other states in which the applicant has

(A) been denied approval to conduct external reviews; or

(B) had approval to conduct external reviews revoked;

(6) evidence of accreditation received from a nationally recognized accrediting entity the director has determined has independent review organization standards that are

equivalent to, or exceed, the minimum qualifications for independent review organizations under 3 AAC 28.974;

(7) a copy of the applicant's written policies and procedures that include evidence of

(A) meeting the qualifications under 3 AAC 28.974(a)(1)(A) – (F); and

(B) ensuring adherence to the requirements under 3 AAC 28.950 – 3 AAC 28.982 by a contractor, subcontractor, agent, or employee affiliated with the independent review organization;

(8) a list of the reviewers retained by the independent review organization with a description of each of their areas of expertise and the types of cases each reviewer is qualified to review;

(9) the name, title, electronic mail address, telephone number, and facsimile transmission number of the physician or health care professional responsible for the supervision and oversight of the independent review procedure; and

(10) a description of the fees to be charged to a health care insurer by the independent review organization for external reviews;

(e) The director may retain an outside expert to perform reviews of applications submitted under this section. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.972. Examination; suspension or revocation of registration. (a) To determine compliance with 3 AAC 28.950 – 3 AAC 28.999, the director may examine the affairs, transactions, accounts, records, and documents of an independent review organization. The director, after a hearing, may suspend or revoke an independent review organization registration for failure to meet the requirements under 3 AAC 28.970(a).

(b) The director shall suspend an independent review organization's registration for a fixed period of time determined by the director, or until the occurrence of a specific event necessary for remedying the reasons for suspension. The director may modify, rescind, or reverse a suspension under this section.

(c) During a period of suspension, the director will not assign the independent review organization to conduct an external review in this state. The independent review organization may continue to conduct an external review assigned before the suspension if the director determines completion of the assignment to be in the best interests of the public. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.974. Minimum qualifications for independent review organizations. (a) An independent review organization is eligible to conduct external reviews under 3 AAC 28.950 – 3 AAC 28.982, if the independent review organization has and maintains written policies and procedures that govern all aspects of the standard external review process and the expedited external review process and include, at a minimum, the following:

(1) a quality assurance mechanism that ensures

(A) external reviews are conducted not later than the specified time frames and that required notices are provided in a timely manner;

(B) the selection of qualified and impartial

(i) clinical reviewers to conduct external reviews on behalf of the independent review organization; and

(ii) suitable matching of reviewers to specific cases;

(C) the independent review organization employs or contracts with an adequate number of clinical reviewers to meet the objectives under (B) of this paragraph;

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

(E) the establishment and maintenance of written procedures to ensure the independent review organization is unbiased in addition to other procedures required under this section;

(F) a person employed by or under contract with the independent review organization adheres to the requirements under 3 AAC 28.950 – 3 AAC 28.982;

(2) a toll-free telephone service to receive information related to external reviews 24 hours a day, seven days a week, that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers outside normal working hours; and

(3) an agreement and a system to maintain required records and to provide the director with access to those records; the agreement must include a provision that the

independent review organization shall reply in writing not later than five working days to a records inquiry of the director.

(b) A clinical reviewer assigned by an independent review organization to conduct an external review must be a physician or other appropriate health care professional who meets the following minimum qualifications:

(1) is an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) is knowledgeable about the recommended or requested health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition as the covered person;

(3) holds a nonrestricted 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

(4) has no history or disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by a 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) 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 health care insurer, a national, state, or local trade association of health care insurers, or a national, state, or local trade association of health care providers.

(d) An independent review organization selected to conduct an external review, or a clinical reviewer assigned by the independent organization to conduct an external review, may not have a material professional, familial, or financial conflict of interest with

(1) the health care insurer that is the subject of the external review;

(2) the covered person whose health care service or treatment is the subject of the external review or the covered person's authorized representative;

(3) an officer, director, or management employee of the health care insurer that is the subject of the external review;

(4) the health care professional or the health care professional's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

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

(6) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose health care service or 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 under (d) of this section, the director 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 (d) of this section, but the characteristics of that relationship or connection are such that they do not constitute a material professional, familial, or financial conflict of interest that would prohibit selection of the independent review organization or the clinical reviewer to conduct the external review.

(f) An independent review organization is presumed to be in compliance with the requirements of this section if the organization is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the director has determined are equivalent to, or exceed, the minimum qualifications of this section.

(g) The director shall initially and periodically review the standards of each nationally recognized private accrediting entity that accredits independent review organizations to determine whether the accrediting entity's standards are, and continue to be, equivalent to, or exceed, the minimum qualifications established under this section. The director may make the determination based on a National Association of Insurance Commissioners review of the standards.

(h) Upon request, a nationally recognized private accrediting entity shall provide its current independent review organization accreditation standards to the director or to the National Association of Insurance Commissioners for the director to determine if the accrediting entity's standards are equivalent to, or exceed, the minimum qualifications established under this section. The director will not consider the accreditation of an independent review organization if the

accrediting entity has not had its standards reviewed by the National Association of Insurance Commissioners. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.976. Immunity for independent review organizations. An independent review organization, a clinical reviewer working on behalf of an independent review organization, or an employee, agent, or contractor of an independent review organization may not be liable in damages to a person for an opinion rendered, or act or omission performed, within the scope of the duties of the organization, the clinical reviewer, or an employee, agent, or contractor of the organization under 3 AAC 28.950 – 3AAC 28.984 during, or upon completion of, an external review conducted under 3 AAC 28.950 – 3AAC 28.984, unless the opinion was rendered, or the act or omission was performed, in bad faith or involved gross negligence. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.978. External review reporting requirements. (a) An independent review organization assigned to conduct an external review shall maintain written records, in the aggregate by state and by health care insurer, of requests for external review for which the independent review organization conducted an external review during a calendar year.

(b) An independent review organization required to maintain written records under this section shall submit to the director, upon request, a report in a format specified by the director. The report must include

(1) the name and mailing address of the independent review organization;

(2) the name, title, electronic mail address, telephone number, and facsimile transmission number of the person completing the report;

(3) the name, title, electronic mail address, telephone number, and facsimile transmission number of the person responsible for regulatory compliance and quality of external reviews; and

(4) in the aggregate by state and by health care insurer the following:

(A) the total number of requests assigned to the independent review organization for

(i) standard external reviews; and

(ii) expedited external reviews;

(B) the average length of time for resolution of requests for external review assigned to the independent review organization for

(i) standard external reviews; and

(ii) expedited external reviews:

(C) the number of medical necessity external reviews decided in favor of a health care insurer and a brief list of the procedures denied;

(D) the number of medical necessity external reviews decided in favor of the covered person and a brief list of the procedures approved;

(E) the number of experimental or investigational external reviews decided in favor of the health care insurer and a brief list of the procedures denied:

(F) the number of experimental or investigational external reviews decided in favor of the covered person and a brief list of the procedures approved;

(G) the number of external reviews terminated as the result of a reconsideration by a health care insurer;

(H) the number of external reviews terminated by the covered person or the covered person's authorized representative before issuance by the independent review organization of the external review decision;

(I) the number of external reviews declined due to possible conflict for each of the following:

(i) health care insurer;

(ii) covered person;

(iii) health care provider;

(J) a brief description of the conflicts identified under (I)(i) – (iii) of this paragraph;

(K) the number of external reviews declined due to other reasons not reflected under (I) of this paragraph.

(c) The independent review organization shall provide to the director documents or information requested by the director not later than five working days after receipt of the request.

(d) The independent review organization shall retain the written records required under this section for at least three years.

(e) A health care insurer shall maintain written records in the aggregate by state and by type of health care insurance policy offered by the health care insurer of all requests for external review that the health care insurer receives notice of from the director under 3 AAC 28.950 – 3 AAC 28.982.

(f) A health care insurer required to maintain written records under this section shall submit to the director, upon request, a report in the format specified by the director. The report must include the following:

(1) name and mailing address of the health care insurer;

(2) name, title, electronic mail address, telephone number, and facsimile transmission number of the person completing the report;

(3) name, title, electronic mail address, telephone number, and facsimile transmission number of the person responsible for regulatory compliance; and

(4) in the aggregate, by state and by type of health plan offered, the following:

(A) the total number of requests for external review of the health care insurer's adverse determinations and final adverse determinations;

(B) the number of requests determined eligible for external review;

(C) the number of requests for external review resolved and, of those resolved,

(i) the number upholding the adverse determination or final adverse determination of the health care insurer; and

(ii) the number reversing the adverse determination or final adverse determination of the health care insurer; and

(D) the number of external reviews that were terminated as the result of reconsideration by the health care insurer of an adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(g) A health care insurer shall provide the director with other requested documents or information not later than five working days after receipt of the request.

(h) A health care insurer shall retain the written records required under this section for at least three years.

(i) A health care insurer shall ensure the health care insurer's person responsible for regulatory compliance identified under (f)(3) of this section or the person's designated alternate is available to the director during the division's normal working hours, 8:00 a.m. to 4:30 p.m., Alaska time zone, Monday through Friday, excluding state holidays. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.980. Funding of external review. A health care insurer 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 to conduct the external review. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

3 AAC 28.982. Disclosure requirements. A health care insurer shall set out in, or attach to, a policy, certificate of coverage, membership booklet, or other evidence of coverage provided to a covered person, a description of the external review procedures described under 3 AAC 28.950 – 3 AAC 28.982. The description must include

(1) a statement of the covered person's or the covered person's authorized representative's right to file a request for an external review of an adverse determination or final adverse determination with the director; the statement must include the division's current mailing address, electronic mail address, telephone number, and facsimile transmission number;

(2) a statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review;

(3) a brief description, including timelines, of each type of external review process; and

(4) a statement of the covered person or the covered person's authorized representative's right to provide additional information or otherwise participate in the external review process. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

Article 13. General Provisions.

Section

3 AAC 28.999. Definitions. In this chapter, unless the context requires otherwise,

(1) "adverse determination" includes a rescission of coverage determination and means

(A) a determination by a health care insurer or the health care insurer's designee utilization review organization that

(i) based upon the information provided, a request for a benefit under the health care insurer's health care insurance policy upon application of a utilization review technique does not meet the health care insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; or

(ii) an admission, availability of care, continued stay or other health care service or treatment that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health care insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated;

(B) the denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health care insurer or the health care insurer's designee utilization review organization of a covered person's eligibility to participate in the health care insurer's health care insurance policy; or

(C) a prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit;

(2) "applicable non-English language" means a non-English language if 10 percent or more of the population residing in a borough equivalent is literate only in the same non-English language as determined in *CLAS County Data, Edition Date: January 2016,* issued by the federal Department of Health and Human Services, Centers for Medicare & Medicaid Services, on January 27, 2016, and adopted by reference.

(3) "authorized representative" means

(A) a person to whom a covered person has given express written consent to represent the covered person for purposes of 3 AAC 28.900 – 3 AAC 28.982;

(B) a person authorized by law to provide substituted consent for a covered person;

(C) one of the following only if the covered person is unable to provide consent:

(i) a family member of the covered person; or

(ii) the covered person's treating health care professional;

(D) a health care professional if the covered person's health care insurance policy requires that a request for a benefit under the plan be initiated by the health care professional; or

(E) if an urgent care request, a health care professional with knowledge of the covered person's medical condition;

(4) "best evidence" means evidence based on randomized clinical trials; if randomized clinical trials are not available, "best evidence" means evidence based on cohort studies or case-control studies; if randomized clinical trials, cohort studies or case-control studies are not available, "best evidence" means evidence based on case-series studies; if none of these are available, "best evidence" means evidence based on expert opinion;

(5) "borough equivalent" means

(A) a unified municipality;

(B) an organized borough; or

(C) a census area used by the United States Secretary of Commerce in the last decennial census that is located in the unorganized borough of the state;

(6) "case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;

(7) "case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group;

(8) "certification" means a determination by a health care insurer or the health care insurer's designee utilization review organization that a request for a benefit under the health care insurer's health care insurance policy has been reviewed and, based on the information provided, satisfies the health care insurer's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(9) "clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;

(10) "clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health care insurer to determine the medical necessity and appropriateness of health care services;

(11) "closed plan" means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(12) "cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions;

(13) "concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting;

(14) "covered benefit" or "benefit" means a health care service to which a covered person is entitled under the terms of a health care insurance policy;

(15) "covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health care insurance policy;

(16) "denial code" means a health care insurer specific identifier indicating the reason why a claim is being denied;

(17) "department" means the Department of Commerce, Community, and Economic Development;

(18) "diagnosis code" means a universal code used by a health care provider to categorize a health condition, illness, injury, or disease;

(19) "director" means the director of the division of insurance;

(20) "disclose" means to release, transfer, or otherwise divulge protected health information to a person other than the individual who is the subject of the protected health information;

(21) "division" means the division of insurance, Department of Commerce, Community, and Economic Development;

(22) "emergency medical condition" has the meaning given in AS 21.07.250;

(23) "emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition;

(24) "evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;

(25) "expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy;

(26) "facility" means an institution providing health care services or a health care setting, including 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;

(27) "final adverse determination" means an

(A) adverse determination that has been upheld by a health care insurer at the completion of the internal appeals process applicable under 3 AAC 28.936 or 3 AAC 28.938; or

(B) adverse determination that, with respect to which the internal appeals process, has been considered exhausted under 3 AAC 28.934(b);

(28) "grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding

(A) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made under utilization review;

(B) claims payment, handling, or reimbursement for health care services; or

(C) matters pertaining to the contractual relationship between a covered person and a health care insurer;

(29) "health care insurance policy" means a policy, contract, certificate, or agreement offered or issued by a health care insurer to provide, deliver, arrange for, pay for, or reimburse the costs of health care services or treatments;

(30) "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;

(31) "health care provider" or "provider" means a health care professional or a facility;

(32) "health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(33) "health care insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a

nonprofit hospital and health service corporation, or other entity providing a plan of health insurance, health benefits, or health care services;

(34) "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 the following:

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

(B) the provision of health care services or treatments to an individual;

(C) payment for the provision of health care services or treatments to an individual;

(35) "independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

(36) "managed care plan"

(A) means a health care insurance policy that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with, or employed by a health care insurer;

(B) includes

(i) a closed plan; and

(ii) an open plan;

(37) "medical or scientific evidence" means evidence found in the following sources:

(A) peer-reviewed scientific studies published in or accepted for publication by medical journals that

(i) meet nationally recognized requirements for scientific manuscripts; and

(ii) submit most of their published articles for review by experts who are not part of the editorial staff;

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

(C) medical journals recognized by the United States Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2) (federal Social Security Act);

(D) the following standard reference compendia:

(i) *American Hospital Formulary Service – Drug Information*;

(ii) *Drug Facts and Comparisons*;

(iii) American Dental Association *Accepted Dental Therapeutics*; and

(iv) *United States Pharmacopoeia – Drug Information*;

(E) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the following:

(i) federal Agency for Healthcare Research and Quality;

(ii) National Institutes of Health;

(iii) National Cancer Institute;

(iv) National Academy of Sciences;

(v) Centers for Medicare & Medicaid Services;

(vi) United States Food and Drug Administration; and

(vii) a national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services or treatments;

(F) other medical or scientific evidence that is comparable to the sources listed in (A) – (E) of this paragraph;

(38) "network" means the group of participating providers providing services to a managed care plan;

(39) "open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for a covered person to use participating providers under the terms of the managed care plan;

(40) "participating provider" means a provider who, under contract with a health care insurer or with the health care insurer's contractor or subcontractor, has agreed to provide

health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health care insurer;

(41) "person" has the meaning given in AS 21.97.900 and includes a joint venture and a joint stock company;

(42) "prospective review" means utilization review conducted before an admission or course of treatment;

(43) "protected health information" means health information

(A) that identifies an individual who is the subject of the information; or

(B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

(44) "randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

(45) "rescission"

(A) means a cancellation or discontinuance of coverage under a health care insurance policy that has a retroactive effect;

(B) does not include a cancellation or discontinuance of coverage under a health care insurance policy if

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

(46) "retrospective review"

(A) means review of medical necessity conducted after services have been provided to a patient;

(B) does not include the review of a claim that is limited to

(i) veracity of documentation; or

(ii) accuracy of coding;

(47) "treatment code" means a universal code used by a health care provider to identify a service or supply provided to an insured under a health care insurance policy;

(48) "urgent care request" means a request

(A) for a health care service or course of treatment with respect to which the time period for making a non-urgent care request determination

(i) could seriously jeopardize the life or health of the covered person to regain maximum function; or

(ii) in the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request:

(B) that an attending health care professional with knowledge of the covered person's medical condition determines is an urgent care request under (A) of this paragraph;

(C) except under (B) of this paragraph, that an individual determines is an urgent care request if the individual is

(i) acting on behalf of a health care insurer; and

(ii) applying the judgment of a prudent layperson who has an average knowledge of health and medicine;

(49) "utilization review" has the meaning given in AS 21.07.250;

(50) "utilization review organization" means an entity that conducts utilization review, other than a health care insurer performing utilization review for the health care insurer's own benefit plans;

(51) "working day" has the meaning given in AS 21.97.900. (Eff. _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.07.005

Editor's note: *CLAS County Data, Edition Date: January 2016*, issued by the federal Department of Health and Human Services, Centers for Medicare & Medicaid Services, on January 27, 2016, may be obtained from the Centers for Medicare & Medicaid Services website at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf, the Alaska Division of Insurance website at https://www.commerce.alaska.gov/web/ins/, or by writing to the Alaska Division of Insurance,

P.O. Box 110805, Juneau, AK 99801-0805, or by contracting the division at insurance@alaska.gov.

Chapter 31. Miscellaneous.

3 AAC 31.060(a) is amended by adding a new paragraph to read:

(37) independent review organization biennial registration fee, $1,000. (Eff. 6/2/88, Register 106; am 7/1/89, Register 110; am 7/1/92, Register 123; am 3/30/94, Register 129; am 3/15/97, Register 141; am 8/23/2001, Register 159; am 12/30/2006, Register 180; am 10/13/2011, Register 200; am 1/1/2014, Register 208; am 9/4/2014, Register 211; am 11/26/2015, Register 216; am 8/20/16, Register 219; am _____/_____/_____, Register _____)

Authority: AS 21.06.090 AS 21.34.040 AS 21.61.109
AS 21.06.250 AS 21.36.355 AS 21.66.210
AS 21.07.005 AS 21.61.105 AS 21.75.045
AS 21.27.025