TITLE XXXVII
INSURANCE

CHAPTER 420-J
MANAGED CARE LAW

Section 420-J:5

420-J:5 Grievance Procedures. – Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

I. Full and fair review shall require that:

(a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;

(b) For medical necessity appeals at least one person reviewing the appeal is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(c) The claimant shall have at least 180 days following receipt of a notification of a claim denial to appeal;

(d) The claimant shall have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;

(e) The claimant shall be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and

(f) The review shall be a de novo proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. In the appeal of a claim denial that is based in whole or in part on a medical judgment:

(a) The review shall be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and

(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process shall be made available which shall provide for:

(a) The submission of information by the claimant to the carrier by telephone, facsimile, or other expeditious method; and

(b) The determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal

(a) In the case of nonexpedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.

(b) In the case of an expedited appeal related to an urgent care claim, a carrier or other entity shall make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with the appeal procedures of the carrier or other licensed entity, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of precisely what is required until the date the claimant responds to the request. The carrier or other licensed entity shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant fails, within a 45-day period from the date of notification, to provide sufficient information, the carrier may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal. The carrier or other licensed entity shall provide a claimant with a written determination of the appeal.

(a) Where a decision is made to uphold, in whole or in part, the denial of benefits, the written determination of appeal shall include:

(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;

(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;

(3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review and options for external review and options for bringing a legal action;

(4) A statement that the claimant 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 claimant's claim for benefits;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(7) If the appeal involves an adverse determination, a copy of the notice of the right to external review that includes the specific requirements for filing an external review; and

(8) A statement describing the claimant's right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.

(b) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall file annually with the commissioner, as part of its annual report required by RSA 420-J:5, V(g), a certificate of compliance stating that the carrier or other licensed entity has established and maintained, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this chapter. Material modifications to the procedure shall be filed with the commissioner prior to becoming effective.

(c) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall maintain written records documenting all grievances and appeals received during a calendar year, a general description of the reason for the appeal or grievance, the name of the claimant, the dates of the appeal or grievance and the date of resolution.

(d) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall provide to consumers:

(1) A description of the internal grievance procedure required under RSA 420-J:5 for claim denials and other matters and a description of the process for obtaining external review under RSA 420-J:5-a-RSA 420-J:5-e. These descriptions shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(2) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(3) A statement that the carrier or other licensed entity will provide assistance in preparing an appeal of an adverse benefit determination, and a toll-free telephone number to contact the carrier or other licensed entity.

(e) (1) If a carrier or other licensed entity provides 2 mandatory levels of appeal, the first

level shall be completed within 15 days and the second level completed within the 30-day time period beginning from the initial date of filing the appeal or grievance. If a carrier or other licensed entity provides a single mandatory level of appeal, the single mandatory level shall be completed within the 30-day time period beginning from the initial date of filing the appeal. With respect to a mandatory second level of appeal involving a claim for continuation of services or urgent care, the carrier or other licensed entity shall make a decision and notify the claimant within 72 hours after the mandatory second level appeal is filed. For appeals involving post-service claims, the carrier shall make a decision and notify the claimant within 60 days of the date the completed appeal was filed.

(2) Subparagraph (e)(1) shall not prohibit a carrier or other licensed carrier from offering additional voluntary levels of appeal in addition to any mandatory levels of appeal offered, provided that:

(A) The claimant may elect to pursue any additional level of appeal under this subparagraph voluntarily;

(B) A carrier may not assert failure to exhaust administrative remedies where a claimant elects to pursue a claim through other venues rather than through the voluntary level of appeal;

(C) Any statute of limitations or time limits to pursue other remedies shall be tolled during the voluntary appeals process;

(D) Voluntary levels of appeal are available only after a claimant has completed required mandatory levels of appeal required under the plan or by regulation;

(E) The carrier provides a claimant with sufficient information to make an informed decision whether to submit the claim through any voluntary appeals process;

(F) No fees or costs are imposed on the claimant as part of any voluntary appeals process; and

(G) Any voluntary level of appeal requested by a claimant under this subparagraph shall be completed within 30 days from the date of the request for the voluntary appeal.

(f) Annual reports shall be made to the insurance commissioner regarding plan complaints, adverse determinations, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.

(g) If the claimant has filed an appeal and the carrier or other licensed entity has not issued a decision within the required time frames, the carrier or other licensed entity shall promptly provide the claimant with a statement of the claimant's right to file an external appeal as provided in RSA 420-J:5-a-RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

VI. In an appeal of a claim denial or other matter, the claimant may authorize a representative to pursue a claim or an appeal by submitting a written statement to the carrier or other licensed entity that acknowledges the representation.

VII. No fees or costs shall be assessed against a claimant related to a request for a grievance or appeal.

Source. 2000, 18:6, 7, 8, 9, 10. 2001, 207:12. 2005, 248:9, 10, 20, eff. Sept. 12, 2005. 2007, 289:27, 28, eff. Jan. 1, 2008.

Section 420-J:5-a

420-J:5-a Right to External Review. –

I. A covered person shall have the right to independent external review of a determination by a health carrier or its designee utilization review entity when all of the following conditions apply:

(a) The subject of the request for external review is an adverse determination;

(b) The covered person has completed the internal review procedures provided by the carrier or other licensed entity pursuant to RSA 420-J:5, or the carrier or other entity has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the carrier or other licensed entity within the required time frames;

(c) (1) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 180 days of the date of the carrier or other licensed entity's denial decision provided pursuant to RSA 420-J:5, or if the carrier or other licensed entity has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due;

(2) The covered person's or covered person's authorized representative's participation in any voluntary level of appeal offered by a carrier or other licensed entity pursuant to RSA 420-J:5, V(e)(2) shall not affect a covered person's ability to submit a request for external review. In the event that a covered person or covered person's authorized representative elects to proceed with a voluntary appeal, that person shall have 180 days from the date the decision is rendered on the voluntary appeal to submit a request for external review.

(d) The covered person's cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of $400;

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this chapter pursuant to paragraph II; and

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review provisions of this chapter pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this chapter, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier.

(b) Health care services provided to inmates by the department of corrections.

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this chapter shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers or medical directors.

Source. 2000, 18:13. 2001, 207:15. 2005, 248:21, eff. Sept. 12, 2005.

Section 420-J:5-b

420-J:5-b Standard External Review. – Standard external review shall be conducted as follows:

I. Within 7 business days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person under the health benefit plan;

(b) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in RSA 420-J:5-a, I; and

(c) The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.

II. Upon completion of the preliminary review pursuant to paragraph I, the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(a) Whether the request is complete; and

(b) Whether the request has been accepted for external review.

III. If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete and to process the request. The covered person or the covered person's authorized representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

IV. If the request for external review is accepted, the commissioner shall:

(a) Include in the notice provided to the covered person pursuant to paragraph II a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the commissioner determines, based on evidence provided by the covered person, that it would not be feasible or appropriate to present only written testimony.

(b) Immediately notify the health carrier in writing of the request for external review and its acceptance.

V. If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

VI. At the time a request for external review is accepted, the commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the external review. The commissioner shall not select the same independent review organization for each external review, but shall rotate among the certified independent review organizations, using all organizations equally. The commissioner may select and retain an independent review organization regardless of the rotation if the commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

VII. Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(b), the health carrier or its designated utilization review organization shall provide to the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(a) The terms of agreement of the health benefit plan, including the evidence of coverage,

benefit summary, or other similar document;

(b) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(c) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(d) The clinical review criteria used and the clinical reasons for the determination;

(e) The relevant portions of the carrier's utilization management plan;

(f) Any communications between the covered person and the health carrier regarding the internal or external review; and

(g) All other documents, information, or criteria relied upon by the carrier in making its determination.

VIII. Failure by the health carrier or the covered person to provide the documents and information required in paragraph IV(a) or VII within the specified time frame shall not delay the conduct of the external review.

IX. The selected independent review organization shall review all of the information and documents received from the carrier pursuant to paragraph VII and any other information submitted by the covered person or the covered person's authorized representative or treating provider with the request for external review or pursuant to subparagraph IV(a) and any testimony provided . In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including those developed or conducted by the federal government, national or professional medical societies, boards, and associations. The independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

X. The selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(a). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

Source. 2000, 18:13, eff. Sept. 3, 2000.

Section 420-J:5-c

420-J:5-c Expedited External Review. – Expedited external review shall be conducted as follows:

I. Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in RSA 420-J:5-b would seriously jeopardize the life or health of the covered person or would jeopardize the

covered person's ability to regain maximum function.

II. Except to the extent that it is inconsistent with the provisions of this paragraph, all requirements for the conduct of standard external review specified in RSA 420-J:5-b shall apply to expedited external review.

III. At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in paragraph I for expedited external review, as well as the reviewability requirements set forth in RSA 420-J:5-b, I. If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

IV. The commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the expedited external review.

V. The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in RSA 420-J:5-b, VII to the selected independent review organization by telephone, facsimile, or any other available expeditious method within one business day of receiving the commissioner's notice of the request for expedited external review pursuant to paragraph III.

VI. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested.

VII. If the notice provided pursuant to paragraph VI was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall:

(a) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(b) Include the information set forth in RSA 420-J:5-b, X.

VIII. An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

IX. A covered person shall not be held liable to either the health plan, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an expedited external review.

Source. 2000, 18:13, eff. Sept. 3, 2000.

Section 420-J:5-d

420-J:5-d Certification of Independent Review Organizations. –

I. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization

satisfies the minimum qualifications established under paragraph II.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph II.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph II is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

(f) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum qualifications established under paragraph II, the commissioner shall terminate the certification of the independent review organization and remove it from the list of certified independent review organizations that is maintained by the commissioner pursuant to subparagraph I(e).

II. To be certified under paragraph I to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

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

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(d) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

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

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

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

(4) Have no history of disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body; and

(5) Have agreed to disclose any potential conflict of interest.

(e) It shall be free of any conflict of interest. To meet this qualification, an independent

review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state, or local trade association of health carriers, or a national, state, or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director, or management employee of the health carrier that is the subject of the external review;

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

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

(5) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(f) Its charges for services provided shall be competitive and reasonable.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, the commissioner may determine, in specific cases, that an affiliation with a hospital, an institution, an academic medical center, or a health carrier provider network does not in and of itself constitute a conflict of interest which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person or the covered person's authorized representative.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

(4) Subsidiaries or affiliates of health plan or health carrier associations.

Source. 2000, 18:13, eff. Sept. 3, 2000.

Section 420-J:5-e

420-J:5-e General Provisions Regarding External Review. –

I. The health carrier against which a request for external review is filed shall pay the cost of the external review. Except under the circumstances described below in this paragraph, such costs shall not exceed $1,500. The commissioner shall notify the independent review organizations of the cost limitation for conducting an external review. The cost for an external review may exceed $1,500 if the commissioner determines an additional cost is necessary to ensure the fair adjudication of the case in question.

II. The external review decision of the independent review organization shall be binding on the health carrier and shall be enforceable by the commissioner pursuant to the penalty

provisions of RSA 420-J:14. The external review decision of the independent review organization shall be binding on the covered person except to the extent the covered person has other remedies available under federal or state law. The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.

III. An independent review organization shall maintain all standards of confidentiality. The records and internal materials prepared for specific reviews by an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

IV. An external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external review, unless the acts or omissions constitute willful and wanton misconduct.

V. The right to external review under this chapter shall not be construed to change the terms of coverage under a health benefit plan nor shall the health carrier retaliate against the covered person for exercising his or her right to an independent external review.

VI. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures under RSA 420-J:5 and the external review process under RSA 420-J:5-a-420-J:5-e.

VII. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, and the number of decisions resolved wholly or partially in favor of the health carrier. Such reports shall also include a separate statement of the number of cases in which the external review was terminated as a result of a reversal by the health carrier of its adverse determination after the receipt of new or additional information from the covered person or the covered person's authorized representative and the number of cases in which the covered person and the health carrier agreed to resolve the dispute prior to a final determination by the independent review organization.

VIII. If, based on the evidence presented during the external review process, the commissioner determines that the health carrier's medical director, in the conduct of his or her duties, may have committed misconduct as set forth in RSA 329:17, VI, the commissioner shall document such findings and transmit them in a separate report to the board of medicine.

Source. 2000, 18:13, eff. Sept. 3, 2000.