

PART Ins 2703 EXTERNAL REVIEW

Statutory Authority: RSA 400-A:15 and RSA 420-J:12

Ins 2703.01 Applicability and Scope.

(a) Except as provided in (b) below, the external review requirements set forth in this rule shall apply to all health carriers that provide or perform utilization review. Any health carrier that makes an adverse determination concerning a covered person shall be considered to be performing utilization review.

(b) The external review requirements set forth in this part shall not apply to determinations relating to:

- (1) Long-term care insurance, as defined by RSA 415-D;
- (2) Coverage under a plan through Medicare, Medicaid, the state Children's Health Insurance Program, Title XXI of the Social Security Act, including services provided under these programs but through a contracted health carrier;
- (3) Health care services provided to inmates by the department of corrections;
- (4) The federal employees health benefits program;
- (5) Coverage issued under chapter 55 of title 10 of the United States Code regarding medical and dental care for members of the Armed Forces;
- (6) Coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; or
- (7) 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.

(c) The external review procedures set forth in this rule 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. #7539, eff 8-1-01; ss by 8862, eff 5-1-07 (from 2703.02); ss by#10918, eff 9-1-15

Ins 2703.02 Definitions. For the purpose of this rule:

(a) "Adverse determination" means a determination by a health carrier or its designee utilization review entity:

- (1) Concerning a requested admission, availability of care, continued stay or other health care service, supply or drug that is a covered benefit under the terms of the covered person's health benefit plan or that could be a covered benefit under some circumstances;
- (2) In which the health carrier or its designee utilization review entity finds that, based upon the information provided, the requested service, supply or drug does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; and
- (3) In which the requested service, supply or drug, or payment for such, is therefore denied, reduced, or terminated.

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

(c) “Authorized representative” means a person to whom a covered person has given consent to represent the covered person in an external review. Authorized representative can include the covered person's treating health care professional.

(d) “Benefits denial” means a denial, reduction, or termination by a health carrier of a requested health care service, supply or drug, or a denial of payment for such, which is made on the basis of a finding by the health carrier that the requested service, supply or drug is specifically excluded from coverage under the terms of the covered person’s health benefit plan and is therefore not a covered benefit.

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

(f) “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

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

(h) “Commissioner” means the insurance commissioner.

(i) “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.

(j) “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(k) “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

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

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

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

(o) “Final adverse determination” means an adverse determination that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier’s standard, second level grievance review process as set forth in RSA 420-J:5, V or expedited, second level grievance review process as set forth in RSA 420-J:5, VI (e).

(p) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

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

(r) “Health care provider” or “provider” means a health care professional or a facility.

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

(t) "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(u) "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:

- (1) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;
- (2) The provision of health care services to an individual; or
- (3) Payment for the provision of health care services to an individual.

(v) "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

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

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

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

- (1) That identifies an individual who is the subject of the information; or
- (2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

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

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

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

(ac) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health plans.

Source. #7539, eff 8-1-01; ss by #8862, eff 5-1-07 (from Ins 2703.01); ss by #10918, eff 9-1-15

Ins 2703.03 The Right to External Review.

(a) 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:

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

(2) 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 health carrier's final denial decision, or if the health carrier has failed to make a decision on appeal within the applicable time frame, then within 180 days of the date the decision was due; and

(3) The category of health care services or type of health benefit plan that is the subject of the request for external review is not excluded from the external review provisions of this rule pursuant to Ins 2703.02 (b).

(b) Benefit denials concerning requested health care services, supplies or drugs that could not be considered a covered benefit under any circumstance shall not be eligible for external review. However, a covered person may receive external review of a benefit denial if it is also an adverse determination.

(c) A benefit denial which shall constitute an adverse determination includes, but is not limited to, the following:

(1) Experimental or investigational treatments, where the health carrier denies requested care because the covered person's health benefit plan does not cover experimental or investigational treatment, but the covered person requests external review on the basis that the treatment in question is not experimental or investigational;

(2) Cosmetic procedures, where the health carrier denies requested care because the covered person's health benefit plan does not cover cosmetic procedures, but the covered person requests external review on the basis that the service is needed for medical rather than cosmetic reasons; and

(3) Access to out-of-network health care professionals or providers, where the health carrier denies a referral because treatment by out-of-network professionals or providers is not covered unless the appropriate clinical expertise is not available within the health carrier's network, but the covered person requests external review on the basis that the health carrier's provider network does not include professionals or providers with the appropriate clinical expertise.

(d) In requesting external review, a covered person shall provide the following information:

(1) The name of the covered person;

(2) The covered person's mailing address, date of birth, telephone number and insurance identification number;

(3) The employer's name and telephone number;

(4) The carrier's name, mailing address, telephone number, and name of contact at the carrier;

(5) The name of the provider, the type of provider, the provider's mailing address, and telephone number;

(6) If applicable, the name, address and telephone number of the authorized representative and a signature giving the representative authority to represent the covered person;

(7) If applicable, a request for a telephone conference;

(8) A statement describing the health care decision in dispute;

(9) A photocopy of the covered person's insurance card and certificate of coverage;

(10) A copy of the final decision of the carrier denying the claim on internal review; and

(11) A statement authorizing the release of the covered person's medical records.

[Source.](#) #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.04 Notice of Right to External Review.

(a) Health carriers shall provide to covered persons the insurance department's "Managed Care Consumer Guide to External Appeal" and the insurance department's "Request for Independent External Appeal of a Health Care Decision" in each of the following circumstances:

- (1) The publications shall be attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons;
- (2) The publications shall be included with the final adverse determination provided to covered persons upon completion of internal grievance review or expedited internal grievance review;
- (3) If the health carrier agrees to submit the determination to independent external review prior to completion of internal review, the publications shall be provided at the time such agreement is made; and
- (4) If the covered person has requested standard or expedited internal grievance review, and the health carrier has failed to issue a decision within the required time frames, the publications shall be provided promptly upon the expiration of the time period for issuing the decision.

(b) Pursuant to the provisions of RSA 420-J:5, V. (a) (3), a notice shall be included with the final determination provided to covered persons upon completion of standard internal grievance review or expedited internal grievance review.

(c) The notice in (b) above shall be:

- (1) In bold;
- (2) Set out in at least 16 point type, and the remainder of the text in at least 12 point type; and
- (3) Printed as follows:

**“NOTICE OF RIGHT TO AN EXTERNAL APPEAL
OF YOUR HEALTH INSURER’S DECISION**

This is our final decision in the internal grievance review process. You may have a legal right to have our decision reviewed by an organization that is independent and neutral. This process is called Independent External Review and is overseen by the New Hampshire Insurance Department. There is no cost to you for an external appeal.

**YOU MUST ASK FOR THIS REVIEW NO LATER THAN 180
DAYS AFTER THE DATE OF THIS NOTICE**

To request an independent external review, consult the enclosed Managed Care Consumer Guide to External Appeal, fill out the enclosed Request for Independent External Appeal of a Health Care Decision, and attach all supporting documentation.”

(d) The person seeking external review shall mail or deliver the completed request to the New Hampshire insurance department at:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

(e) The notice in (b) above shall also include a statement as follows:

“If your medical condition is such that waiting for the standard external review process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for expedited external review.

If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant.”

(f) Pursuant to the provisions of RSA 420-J:5, V (a)(3), if the health carrier agrees to submit the determination to independent external review prior to completion of internal review, the following notice shall be provided to the covered person at the time of the agreement:

(g) The notice in (f) above shall be:

- (1) In bold;
- (2) Set out in at least 16 point type, and the remainder of the text in at least 12 point type; and
- (3) Printed as follows:

**“NOTICE OF RIGHT TO AN EXTERNAL APPEAL
OF YOUR HEALTH INSURER’S DECISION**

We have agreed to submit your appeal of our determination to an independent reviewer prior to completion or our internal grievance review process. This means that you may now have our decision reviewed by an organization that is independent and neutral. This process is called Independent External Review and is overseen by the New Hampshire Insurance Department. There is no cost to you for an external appeal.

**YOU MUST ASK FOR THIS REVIEW NO LATER THAN 180 DAYS
AFTER THE DATE OF THIS NOTICE**

To request an independent external review, consult the enclosed Managed Care Consumer Guide to External Appeal, fill out the enclosed Request for Independent External Appeal of a Health Care Decision, and attach all supporting documentation.

(h) The person seeking external review shall mail or deliver the completed request to the New Hampshire insurance department at:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

(i) The notice in (f) above shall also include a statement as follows:

“If your medical condition is such that waiting for the standard external review process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for expedited external review.

If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant.”

(j) Pursuant to RSA 420-J:5, V (a)(3), if the covered person has requested standard or expedited internal grievance review and the health carrier has failed to issue a decision within the required time frames, the health carrier shall send the following notice to the covered person promptly upon the expiration of the time period for issuing the decision:

(k) The notice in (j) above shall be:

- (1) In bold;
- (2) Set out in at least 16 point type, and the remainder of the text in at least 12 point type; and
- (3) Printed as follows:

**“NOTICE OF RIGHT TO AN EXTERNAL APPEAL
OF YOUR HEALTH INSURER’S DECISION**

We have agreed to submit your appeal of our determination to an independent reviewer prior to completion or our internal grievance review process. This means that you may now have our decision reviewed by an organization that is independent and neutral. This process is called Independent External Review and is overseen by the New Hampshire Insurance Department. There is no cost to you for an external appeal.

**YOU MUST ASK FOR THIS REVIEW NO LATER THAN 180 DAYS
AFTER THE DATE OF THIS NOTICE**

To request an independent external review, consult the enclosed Managed Care Consumer Guide to External Appeal, fill out the enclosed Request for Independent External Appeal of a Health Care Decision, and attach all supporting documentation."

(1) The person seeking external review shall mail or deliver the completed request to the New Hampshire insurance department at:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

(m) The notice in (j) above shall also include a statement as follows:

"If your medical condition is such that waiting for the standard external review process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for expedited external review. If you have any questions about the external review process, please call the New Hampshire Insurance Department at 1-800-852-3416 and ask to speak to a consumer assistant."

[Source.](#) #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.05 Standard External Review. Standard external review shall be conducted as follows:

(a) Within 7 business days after the date of receipt of a request for external review, the department shall complete a preliminary review of the request to determine whether:

- (1) The individual is or was a covered person under the health benefit plan;
- (2) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in Ins 2703.03 (a); and
- (3) The covered person has provided all the information and forms that are necessary to process a request for an external review.

(b) Upon completion of the preliminary review pursuant to Ins 2703.05 (a), the department shall immediately notify the covered person or the covered person's authorized representative in writing:

- (1) Whether the request is complete; and
- (2) Whether the request has been accepted for external review.

(c) If the request is not complete, the department 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.

(d) If the request for external review is accepted, the department shall:

- (1) Notify the covered person that new or additional information can be submitted to the insurance department;
- (2) Notify the covered person that oral testimony shall be permitted only 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;
- (3) Notify the covered person that the request for a hearing shall be made no less than 10 days after the date of issuance of the notice of acceptance;
- (4) Notify the covered person that if the request for oral testimony is accepted that oral testimony shall be taken within 20 days of the date of notice of acceptance and that a representative of the health carrier shall be permitted to participate in the hearing or teleconference; and
- (5) Notify the health carrier in writing of the request for external review and its acceptance, and provide the health carrier with a copy of the request and of any supporting documentation submitted by the covered person or the covered person's authorized representative.

(e) If the request for external review is not accepted, the department 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.

(f) 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 Ins 2703.07 to conduct the external review.

(g) Within 10 days after the date of issuance of the notice provided pursuant to Ins 2703.05 (b)(2), the health carrier or its designated utilization review organization shall provide to the selected independent review organization, the covered person, and the insurance department all information in its possession that is relevant to the adjudication of the matter in dispute, including:

- (1) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary, or other similar document;
- (2) 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;
- (3) A summary description of the applicable issues, including a statement of the health carrier's final determination;
- (4) The clinical review criteria used and the clinical reasons for the determination;
- (5) The relevant portions of the carrier's utilization management plan;
- (6) Any communications between the covered person and the health carrier regarding the internal or external review of the claim; and
- (7) All other documents, information, or criteria relied upon by the carrier in making its determination.

(h) Failure by the health carrier or the covered person to provide the documents and information required in Ins 2703.05 (g) or Ins 2703.05 (d) (1) within the specified time frame shall not delay the conduct of the external review. If upon receipt of a notice from the insurance department the health carrier or its designee utilization review organization has failed to provide the documents and information within the time frame specified in paragraph (g), the commissioner shall terminate the external review and make a decision to reverse the adverse determination or final determination.

(i) The selected independent review organization shall review all of the information and documents received from the carrier pursuant to Ins 2703.05 (g) 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 Ins 2703.05 (d) (1) and any testimony provided.

(j) 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.

(k) In conducting the review, the independent review organization shall review the correctness of all previously determined facts, allow the introduction of new information, and make a decision that is independent of the decisions or conclusions made by the health carrier during internal review.

(l) 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, the health carrier, and the commissioner in writing within 20 days of the date that the record of the case is closed pursuant to Ins 2703.05 (d) (1). 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, and a description of the qualifications of the reviewer or reviewers.

(m) Upon receipt of a notice of a decision pursuant to Ins 2703.05 (j) reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination and provide confirmation of this to the insurance department. The confirmation provided to the insurance department shall include a statement of the amount of payment that was approved and the amount charged.

(n) Upon receipt of the information required to be forwarded by the covered person or the commissioner to the health carrier pursuant to Ins 2703.05 (d) (1) and (2) and prior to receipt of the decision of the selected independent review organization, the health carrier may reconsider the adverse determination or final adverse determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(o) The external review shall only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(p) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in Ins 2703.05 (m), the health carrier shall notify the covered person, and if applicable, the covered person's authorized representative, the selected independent review organization, and the commissioner in writing of its decision and shall approve the coverage that was the subject of the adverse determination or final adverse determination. The selected independent review organization shall terminate the external review upon receipt of the notice from the health carrier and verification that coverage was approved.

[Source.](#) #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.06 Expedited External Review. Expedited external review shall be conducted as follows:

(a) Expedited external review shall be available when the covered person's treating health care provider certifies to the department 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. A person who meets the standard for expedited external review may pursue expedited external review simultaneous with the internal review process in RSA 420-J:5, even without a final adverse determination.

(b) Except to the extent that it is inconsistent with the provisions of this section, all requirements for the conduct of standard external review specified in Ins 2703.05 shall apply to expedited external review.

(c) At the time the department receives a request for an expedited external review, the department shall immediately make a determination whether the request meets the standard set forth in Ins 2703.06 (a) for expedited external review, as well as the reviewability requirements set forth in Ins 2703.05 (a). If these conditions are met, the department shall immediately notify the health carrier. If the request is not complete, the department 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.

(d) If the commissioner determines that the covered person is eligible for external review on an expedited basis, the department shall select and retain an independent review organization that is certified pursuant to Ins 2703.07 to conduct the expedited external review.

(e) The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in Ins 2703.05 (g) to the selected independent review organization electronically or by telephone or facsimile or any other available expeditious method within one business day of receiving notification from the department of the request for expedited external review and of the commissioner's determination that the covered person is eligible for external review on an expedited basis.

(f) 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 by the commissioner's office.

(g) If the notice provided pursuant to Ins 2703.06 (f) was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall:

- (1) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and
- (2) Include the information set forth in Ins 2703.05 (j).

(h) Upon receipt of a notice of a decision pursuant to Ins 2703.05 (j) reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination and provide confirmation of this to the insurance department. The confirmation provided to the insurance department shall include a statement of the amount of payment that was approved.

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

(j) If the expedited external review concerns a concurrent review determination, the service shall be continued pending the completion of the external review process. 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 co-payment, coinsurance, or deductible incurred, pending the independent review organization's determination of an expedited external review.

(k) When a covered person has requested expedited, second-level internal grievance review with a health carrier, the health carriers shall immediately notify the insurance department of the existence of the request and of the expected time frame for making a decision on that request.

Source. #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.07 Certification of Independent Review Organizations.

(a) The certification of independent review organizations shall be conducted as follows:

- (1) An independent review organization seeking certification shall supply the following information:
 - a. Name, address and telephone number of the organization;
 - b. The name, address, and telephone number of the chief executive officer;
 - c. The tax status and federal employer tax identification number;
 - d. The list of states where the organization is incorporated, licensed, certified, or otherwise authorized to conduct business;
 - e. A description of the organizational structure that identifies and explains the lines of authority within the organization itself and if applicable within a holding company or parent subsidiary system;
 - f. A description of the management of the organization, including the files and management responsibilities of the staff;
 - g. A description of the contracted service providers and clinical peer reviewers, as well as a description of the procedures used to ensure the adequacy of the network of clinical peer reviewers retained by the organization and the procedures used to ensure that the peer reviewers are adequately trained and appropriately licensed;
 - h. A list of all reviewers in the clinical peer review network including the name, license number and clinical discipline of each reviewer;
 - i. A description and copy of the quality assurance program established by the organizations, which specifically address the policies and procedures used to protect the confidentiality of medical and treatment records;
 - j. The name of the medical director, and a description of the medical director's qualifications;
 - k. A description of the procedures that will be used to ensure that standard and expedited appeals are conducted within the required time frames;
 - l. A description of the current financial status of the organization, including the most recent certified financial statement;
 - m. A list of fees that will be charged for independent review and an explanation of the methodology used to develop the fee schedule;
 - n. A conflict of interest attestation signed by each owner, officer, director, medical director or management employee of the applicant, which shall be supported by personal information including the name, address, telephone number, and the person's 10 year employment history;
 - o. A statement verifying that any person subject to the requirement of filing a conflict of interest attestation has submitted a report of his/her history of legal actions, as well as a report of his/her affiliation with other health care corporations; and

p. Evidence of accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations.

(2) The application shall be signed by the chief executive officer and the board chairman who shall attest to its accuracy;

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

(4) The commissioner shall periodically review the accreditation for all certified independent review organizations;

(5) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum qualifications established under Ins 2703.07 (b), 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 Ins 2703.07 (a) (5); and

(6) A certification under this section shall be valid for a period of 2 years.

(b) To be certified under Ins 2703.07 (a) to conduct external reviews, an independent review organization shall, in addition to maintaining accreditation by a nationally recognized accrediting entity, meet the following minimum qualifications:

(1) 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;

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

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

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

c. Ensures the confidentiality of medical and treatment records;

d. Ensures that any potential conflict of interest is promptly detected and either remedied by the substitution of an alternative clinical peer reviewer or reported to the commissioner for instruction as to how to proceed; and

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

(3) It shall assign clinical peer reviewers to conduct external reviews who:

a. Are physicians or other appropriate health care providers;

b. Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

c. Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

d. 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;

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

f. Have agreed to promptly disclose any potential conflict of interest.

(4) The independent review organization shall be free of any conflict of interest and shall 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; and

(5) 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 shall have a material professional, familial or financial interest in or relationship with or to any of the following:

a. The health carrier that is the subject of the external review;

b. Any officer, director, or management employee of the health carrier that is the subject of the external review;

c. 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;

d. The facility or institution at which the recommended health care service or treatment would be provided;

e. 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

f. The covered person or the covered person's authorized representative.

(c) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Ins 2703.07 (b) (5), the commissioner shall consider whether the relationship has the potential to directly or indirectly cause the interests of the IRO or its agents or employees acting on its behalf, to interfere with the independent external reviews of health carrier determinations conducted by the independent review organization.

(d) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, an affiliation with a hospital, an institution, an academic medical center, or a health carrier provider network shall not be deemed by itself to 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 and the covered person does not object.

(e) 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.

(f) The external review organization's charges for services provided shall be competitive and reasonable, consistent with Ins 2703.09(a).

Source. #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.08 External Review Reporting Requirements.

(a) An independent review organization assigned by the commissioner to conduct external reviews shall submit an annual report to the commissioner including the following information in the aggregate and separately for each health carrier:

- (1) The total number of requests for external review assigned by the commissioner to the independent review organization;
- (2) The total number of requests for external review assigned by the commissioner to the independent review organization for which a final adjudication was made, and, of those, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;
- (3) The average length of time required for the adjudication;
- (4) A summary of the types of coverages or cases for which an external review was sought;
- (5) The number of external reviews that were terminated prior to completion as the result of a reconsideration and reversal by the health carrier of its adverse determination or final adverse determination after the receipt of new or additional information from the covered person or the covered person's authorized representative;
- (6) The number of external reviews that were terminated prior to completion as the result of a settlement between the health carrier and the covered person on terms other than the original determination of the health carrier or a complete reversal of that determination;
- (7) The number of external reviews that were terminated prior to completion for other reasons; and
- (8) Verification that the organization maintains written records fully documenting requests for external review received from the commissioner.

(b) The independent review organization shall retain all files, records and data received or created in conjunction with external reviews conducted pursuant to this rule for at least 3 years.

Source. #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15

Ins 2703.09 General Provisions Regarding External Review.

(a) 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. Costs in excess of \$1,500 shall be allowed if the commissioner determines an additional cost is necessary to ensure the fair adjudication of the case in question.

(b) 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.

(c) 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.

(d) An independent review organization and the commissioner shall not disclose protected health information regarding covered persons that is collected in the external appeal process. In addition, the records and internal materials prepared for specific reviews by the commissioner and by an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

(e) An independent 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.

(f) 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.

(g) 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.

(h) 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. #7539, eff 8-1-01; ss by #8862, eff 5-1-07; ss by #10918, eff 9-1-15