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Utilization Review, Grievances and External Review

Sec. 38a-591-1. Utilization review company licenses

(a) No utilization review company shall conduct utilization review in this state unless it has been licensed by the commissioner in accordance with section 38a-591j of the Connecticut General Statutes. All requests for licensure shall be made in a manner and on a form prescribed annually by the commissioner.

(b) Applications for licensure will not be considered complete and eligible for processing until all required information is provided.

(c) The annual license fee shall be submitted in check form made payable to the “Treasurer – State of Connecticut”.

(d) All licenses shall be renewed no later than October 1 annually.

(e) The annual license fee will not be pro-rated if issued for a period less than a full year.

(Effective September 4, 2012)

Sec. 38a-591-2. Compensation based on certification denials – prohibited

(a) No staff member, officer or consultant of a utilization review company or a health carrier shall receive any financial incentive based on the number of denials of certifications made.

(b) No utilization review company or health carrier shall receive any financial incentive based on the number of denials of certifications made.

(Effective September 4, 2012)

Sec. 38a-591-3. Confidentiality

(a) Each utilization review company shall comply with the provisions of this section as well as all applicable federal and state laws to protect the confidentiality of patient medical records. Each utilization review company shall:

(1) Secure each case file by assigning case identification numbers to all utilization review requests, and use such numbers in lieu of personally identifiable information, whenever feasible.

(2) Ensure that all paper copies of files are reasonably secured in appropriate storage facilities.

(3) Maintain appropriate written procedures for the requesting, maintenance, and disposition of patient medical records.

(4) Develop and maintain specifications indicating when and by whom the release of patient medical records is permitted.

(5) Ensure that all utilization review business operations are reasonably secured during non-business hours.

(6) Require all employees with access to patient medical records to sign a confidentiality statement, to be maintained on file by the company, in which the employee acknowledges the confidential nature of such information.

(7) Maintain a written policy stipulating sanctions for an employee’s unauthorized disclosure of patient medical records, up to and including termination of employment.

(8) Maintain procedures for limiting access to computer files containing patient medical records through passwords, restricted functions and computer terminal security.

(9) Develop and maintain procedures to address the security of all patient medical records that are transferred by facsimile, which shall include:

(i) A statement in all facsimile transmission cover sheets that such data is confidential and is limited specifically for use by the company in making a utilization review determination; and

(ii) Security procedures governing the use of facsimile transmissions, specifying restricted access to such transmissions, the extent of such information that may be released, and the placement of the facsimile machine in a reasonably secured or isolated area.

(b) Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(Effective September 4, 2012)

Sec. 38a-591-4. Recordkeeping

With respect to all utilization reviews, urgent care or expedited utilization reviews, grievances of adverse determinations, and expedited reviews of adverse determinations, each utilization review company shall maintain an audit trail, through a written control log or computer report, clearly evidencing:

(1) the date that a request or grievance was received;

(2) the dates and reasons for any subsequent requests for additional information required to complete any such review or grievance;

(3) the dates of the receipt of the additional information; and

(4) the date of notification to the provider of record or the covered person or the covered person's authorized representative.

(Effective September 4, 2012)

Sec. 38a-591-5. Statistical reporting to the commissioner

(a) Each health carrier shall file annually with the commissioner, on or before March 1, a summary report of its utilization review program activities in the calendar year immediately preceding and a report that includes for each type of health benefit plan offered by the health carrier the required information set forth in subsection (e)(1)(B) of section 38a-591b of the Connecticut General Statutes.

(b) Each health carrier shall report the information indicated in a format as specified annually by the commissioner and shall maintain source records adequate to support the accuracy of the information filed.

(Effective September 4, 2012)

Sec. 38a-591-6. Examinations

(a) The commissioner may undertake a compliance examination of any utilization review company licensed and conducting business in this state. In conducting the examination, the commissioner or his designee may examine the offices of such utilization review company, its books, records, procedures and any other information deemed to be relevant to the examination.

(b) Upon completing the compliance examination, the commissioner or his designee shall issue a report of the examination. The report shall include any corrective or remedial actions deemed necessary to be taken by the utilization review company in order to assure compliance with the requirements of Connecticut law.

(Effective September 4, 2012)

Sec. 38a-591-7. Grievance procedures

(a) Each health carrier shall file with the commissioner a copy of the written procedures, including all forms used to process requests, for (1) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (2) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a

facility, and (3) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(b) Each health carrier shall file with the commissioner an initial copy of such procedures, including all forms used to process requests, no later than September 1, 2012 and any subsequent material modifications to such procedures no later than one month following implementation of the modification.

(Effective September 4, 2012)

Sec. 38a-591-8. Notice to enrollees

(a) Each health carrier that submits notices to a covered person or the covered person's authorized representative pursuant to section 38a-591d of the Connecticut General Statutes, including adverse determinations that involve a rescission, shall include with the Notice of Adverse Determination a description of the health carrier's procedures for initiating an internal grievance of an adverse determination including the procedures for requesting an expedited review. Such notification shall also include the procedures for filing an external review and an expedited external review.

(b) Each health carrier that submits a notice to a covered person or the covered person's authorized representative pursuant to section 38a-591e of the Connecticut General Statutes shall include with the Notice of a Grievance Decision that upholds the adverse determination a description of the health carrier's procedures for initiating any remaining internal grievance rights including the procedures for requesting an expedited review. If the Notice of a Grievance Decision that upholds the adverse determination is the final adverse determination, or if the notice is issued due to the health carrier's failure to strictly adhere to the requirements of section 38a-591e(f)(1) of the Connecticut General Statutes, the notice shall also include a statement that all internal appeals have been exhausted. Such notice shall include the procedure for filing an external review and an expedited external review, as well as a copy of the external review application and a consumer guide to the external review process. The commissioner shall develop and make available to health carriers the external review application and consumer guide to the external review process. A copy of the external review application and consumer guide shall also be made available from the health carrier to a covered person or the covered person's authorized representative, upon request.

(Effective September 4, 2012)

Sec. 38a-591-9. Rescission notice

Health carriers shall provide advance written notice, consistent with 45 C.F.R. 136, to each covered person who would be affected before coverage may be rescinded regardless of whether the rescission applies to an entire group or only to an individual within the group.

(Effective September 4, 2012)

Sec. 38a-591-10. Independent review organizations

(a) The commissioner shall enter into agreements for external review services with as many independent review organizations as he deems necessary. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review.

(b) After entering into an agreement with the commissioner, an independent review organization shall report changes in its ownership, or its operational or administrative status to the commissioner not later than thirty (30) days after the effective date of such change. If the commissioner determines that the reported

change(s) may negatively impact the effectiveness or objectivity of the independent review organization, the commissioner may terminate the agreement.

(Effective September 4, 2012)

Sec. 38a-591-11. Severability

If any provision of sections 38a-591-1 to 38a-591-11, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of said regulations, and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 4, 2012)