40-22a13. External review of adverse health care decisions; definitions. On and after July 1, 2011, for the purposes of K.S.A. 40-22a13 through 40-22a16, and amendments thereto:

(a) "Adverse decision" means a utilization review determination by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and:

(1) If the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services; or

(2) the adverse decision is the reason for the insured not receiving the requested services.

(b) "Emergency medical condition" means:

(1) The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;

(2) a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or

(3) a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

(c) "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event the entity has no Kansas providers available who are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in such health care provider's practice outside the state of Kansas.

(d) "Health insurance plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans.

(e) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group-funded pool, and the self-funded coverage established by the state of Kansas, or any hospital or medical expense, health, hospital or medical service corporation contract or a plan provided by a municipal group-funded pool.

(f) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group-funded pool and the self-funded coverage established by the state of Kansas for its employees.

History: L. 1999, ch. 162, § 6; L. 2011, ch. 111, § 2; L. 2015, ch. 45, § 5; July 1.