40-22a15. Same; insurance commissioner's powers and duties; external review organizations, decisions, immunity from liability; fees, responsibility for. On and after July 1, 2011:

(a) The commissioner shall:

(1) Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health insurance plan or insurer;

(2) allow the insurer or the health insurance plan, an insured or treating physician or health care provider acting on behalf of the insured, or legally authorized designee filing a request for external review to provide additional written information as may be relevant for the commissioner to make a final decision on whether the request qualified for external review;

(3) make a decision on a request for external review within 10 business days after receiving all necessary information;

(4) notify the insured and treating physician or health care provider acting on behalf of the insured, or legally authorized designee, and insurer or health insurance plan in writing that a request for external review will or will not be granted; and

(5) design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision.

(b) The external review organization as defined in subsection (c) of K.S.A. 40-22a13, and amendments thereto, shall provide that all reviews completed pursuant to K.S.A. 40-22a13 through 40-22a16, and amendments thereto, are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the performance of the external review organization's duties in K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(c) The external review organization shall issue a written decision to the insured and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within 30 business days. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review shall be whether the health care service denied by the insurer or health insurance plan was covered or excluded from coverage under the terms of the insured's contract.

(d) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues not more than 72 hours after the date of receipt of the request for an expedited external review, or as expeditiously as the insured's medical condition or circumstances require.

(e) The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

(f) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured, health insurance plan or insurer for any opinion rendered as part of an external review conducted pursuant to K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(g) The external review organization shall maintain confidentiality of the medical records of the insured in accordance to state and federal law.

(h) The external review organization's fee for performance of any external review may be paid by the commissioner, the insurer or the health insurance plan. In no event shall the insured be held responsible for any portion of such fee.

History: L. 1999, ch. 162, § 8; L. 2011, ch. 111, § 4; July 1.