DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 (18 **Del.C.** §311)
18 **DE Admin. Code** 1301

FINAL

ORDER

1301 Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims

Proposed amendments to Regulation 1301 relating to internal review, arbitration and independent utilization review of health insurance claims, were published in the *Register of Regulations* on November 1, 2008. The comment period remained open until December 1, 2008. There was no public hearing on proposed amendments to Regulation 1301. Public notice of the proposed amended Regulation 1301 in the *Register of Regulations* was in conformity with Delaware law.

Summary of the Evidence and Information Submitted

Public comment was received from six sources. The Delaware Chapter of the American College of Emergency Physicians, Doctors for Emergency Service, and the Delaware Healthcare Association expressed support for the proposed modifications. State Farm Mutual Insurance Company, the State Council for Persons with Disabilities, and the Delaware Developmental Disabilities Council issued comments; however, none of those comments were to the proposed amendments to Regulation 1301. Those comments were directed to the sections of Regulation 1301 not being amended. The proposed change allows better access to medical care for Delaware residents and creating a safety net for both those residents and medical providers.

Findings of Fact

Based on Delaware law and the record in this docket, I make the following findings of fact:

1. The proposed amendments streamline and improve procedures put into place upon the previous amendments to Regulation 1301 in June, 2007.
2. The proposed amendments comply with Delaware law.
3. The suggested changes received in the aforementioned comments are not relevant to the proposed amendments.

Decision and Effective Date

Based on the provisions of 18 **Del.C.** §§311(a) and 6408 and 29 **Del.C.** §§10113-10118 and the record in this docket, I hereby adopt amended Regulation 1301 as amended and as may more fully and at large appear in the version attached hereto to be effective on January 12, 2009.

Text and Citation

The text of proposed amended Regulation 1301 last appeared in the *Register of Regulations* Vol. 12, Issue 5, pages 611-620.

IT IS SO ORDERED this 8th day of December, 2008.

Matthew Denn, Insurance Commissioner

1301 Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 **Del.C**. §§332, 6416 and 6417 which require health insurance carriers to establish a procedure for internal review of a carrier's adverse coverage determination and which require the Delaware Insurance Department to establish and administer procedures for arbitration and independent utilization review upon completion of the carrier's internal review process. This Regulation also implements 18 **Del.C.** §§3349 and 3565, which require the Delaware Insurance Department to establish and administer procedures for arbitration of disputes between health insurance carriers and non-network providers of emergency care services. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 332, 3349, 3565 and 6408 and 29 **Del.C.**, Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

2.1 The following words and terms, when used in this regulation, should have the following meaning unless the context clearly indicates otherwise:

"**Adverse determination**" means a decision by a carrier to deny (in whole or in part), reduce, limit or terminate health insurance benefits.

"**Appeal**" means a request for external review of a carrier's final coverage decision through the Independent Health Care Appeals Program.

"**Appropriateness of services**" means an appeal classification for adverse determinations that are made based on identification of treatment as cosmetic, investigational, experimental or not an appropriate or preferred treatment method or setting for the condition for which treatment is sought.

"**Authorized representative**" means an individual who a covered person willingly acknowledges to represent his interests during the internal review process, arbitration and/or an appeal through the Independent Health Care Appeals Program, including but not limited to a provider to whom a covered person has assigned the right to collect sums due from a carrier for health care services rendered by the provider to the covered person. A carrier may require the covered person to submit written verification of his consent to be represented. If a covered person has been determined by a physician to be incapable of assigning the right of representation, the covered person may be represented by a family member or a legal representative.

"**Carrier**" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"**Covered person**" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

"**Department**" means the Delaware Insurance Department.

"**Duration of an Emergency Medical Condition**" means a period of time that begins with an Emergency Medical Condition and ends when the Emergency Medical Condition is either treated or stabilized as such stabilization is evidenced by post stabilization care [as referenced in 18 **Del.C.** §§3349(c)(3) and 3565(c)(3)] in a hospital where such post stabilization care is not within the definition of emergency care services.

"**Emergency care provider**" means a provider of emergency care services.

~~"**Emergency care services**" means those services identified in 18 **Del.C.** §§3349(c) and 3565(c)~~ including~~:~~ a provider who also provides health care services that aren't emergency care services.

~~A. Any~~ "**Emergency care services**" means those services identified in 18 **Del.C.** §§3349(c) and 3565(c) performed at any time during the Duration of an Emergency Medical Condition, including any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met~~; and~~

~~B. Facility and professional providers of emergency medical services in an approved emergency care facility.~~

"**Emergency ~~m~~Medical ~~c~~Condition**" shall have the meaning assigned to it by 18 **Del.C.** §§3349(d) and 3565(d).

"**Final coverage decision**" means the decision by a carrier at the conclusion of its internal review process upholding, modifying or reversing its adverse determination.

"**Grievance**" means a request by a covered person or his authorized representative that a carrier review an adverse determination by means of the carrier's internal review process.

"**Health care services**" means any services or supplies included in the furnishing to any individual of medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

"**Health insurance**" means a plan or policy issued by a carrier for the payment for, provision of, or reimbursement for health care services.

"**Independent Health Care Appeals Program ("IHCAP")**" means a program administered by the Department that provides for an external review by an Independent Utilization Review Organization of a carrier's final coverage decision based on medical necessity or appropriateness of services.

"**Independent Utilization Review Organization ("IURO")**" means an entity that conducts independent external reviews of a carrier's final coverage decisions resulting in a denial, termination, or other limitation of covered health care services based on medical necessity or appropriateness of services.

"**Internal review process ("IRP")**" means a procedure established by a carrier for internal review of an adverse determination.

"**Medical necessity**" means providing of health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

A. In accordance with generally accepted standards of medical practice;

B. Consistent with the symptoms or treatment of the condition; and

C. Not solely for anyone's convenience.

"**Network carrier**" is a carrier that has a written participation agreement with ~~an emergency care~~ a provider to pay for emergency care services ~~in Delaware~~.

"**Network ~~e~~Emergency ~~c~~Care ~~p~~Provider**" is a~~n emergency care~~ provider who has a written participation agreement with the carrier to provide emergency care services or governing payment of emergency care services ~~in Delaware as of the date those services were provided. All other emergency care providers shall be considered non-network emergency care providers~~.

"**Non-Network Emergency Care Provider**" is a provider who is not a Network Emergency Care Provider.

"**Provider**" means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides health care services in this State.

3.0 Minimum Requirements for an Internal Review Process (IRP)

In addition to the requirements set forth in 18 **Del.C.** §332, the following provisions shall govern the internal review process of all carriers offering health insurance in Delaware:

3.1 All written procedures and forms utilized by a carrier shall be readable and understandable by a person of average intelligence and education. All such documents shall meet the following criteria:

3.1.1 The type size shall not be smaller than 11 point;

3.1.2 The type style selection shall be at the discretion of the carrier but shall be of a type that is clear and legible;

3.1.3 Captions or headings shall be designed to stand out clearly;

3.1.4 White space separating subjects or sections should be distinct;

3.1.5 There must be included a table of contents sufficient to guide and assist the covered person or his authorized representative;

3.1.6 Where appropriate, definitions shall be included, shall be sufficient to clearly apply to the usage intended, and shall not conflict with the definitions contained in this regulation.

3.1.7 The forms shall be written in everyday, conversational language to the extent possible to preserve the legal meaning.

3.1.8 Short familiar words shall be used and sentences shall be kept as short and simple as possible.

3.2 The carrier shall provide all forms relating to grievances, appeals, arbitration or other procedures relating to IRP as examples along with the written notice of IRP provided to the covered person.

3.3 Written notice.

3.3.1 For any IRP not previously approved by the Department, the carrier shall provide written notice of the IRP to all covered persons within 30 days of approval by the Department.

3.3.2 The carrier shall provide the annual notice required by 18 **Del.C.** §332(c)(1) to covered persons either upon the policy renewal date, open enrollment date, or a set date for all covered persons, in the carrier's discretion.

3.3.3 For every new policy issued after the Department's approval of the IRP, the carrier shall provide covered persons with a copy of the IRP at the time, or prior to the time, the carrier sends identification cards, member handbooks or similar member materials to newly covered persons.

3.3.4 When a covered person's dependents are also covered, a single notice to the principal covered person shall be sufficient under this section.

3.4 Under circumstances where an oral or written grievance may not contain sufficient information and the carrier requests additional information, such request shall not be burdensome or require such information as the carrier might reasonably be expected to obtain through its normal claims process.

4.0 Mediation Services

At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if the decision does not authorize payment of the claim in its entirety, the carrier shall provide the covered person with a written notice of mediation services offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision. Any notice provided to a covered person shall, at a minimum, contain the following language:

> "You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to review of this decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process. All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

5.0 Options for External Review of a Carrier's Final Coverage Decision

5.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through the Department by filing either a Petition for Arbitration or filing an appeal through the Independent Health Care Appeals Program, depending on the basis for the carrier's final coverage decision as set forth herein.

5.2 Arbitration (sections 6.0 and 7.0 of this regulation). Except for claims exempt from arbitration by law or regulation, every carrier, provider, network emergency care provider and non-network emergency care provider as defined in this regulation shall submit the following to arbitration ~~the following~~:

5.2.1 covered claims arising from the provision of emergency care services under 18 **Del.C.** §§3349 and 3565; and

5.2.2 final coverage decisions denying claims based on grounds other than medical necessity or appropriateness of services.

5.3 Independent Health Care Appeals Program (sections 8.0 through 11.0 of this regulation). A carrier shall submit all requests for review of final coverage decisions denying claims based, in whole or in part, on medical necessity or appropriateness of services ("appeals") to the Independent Health Care Appeals Program ("IHCAP").

5.3.1 For cases in which a carrier's final coverage decision should be reviewed through arbitration and through IHCAP, or where there is an ambiguity as to whether review should be through arbitration or through IHCAP, review shall be conducted through IHCAP.

5.4 Exemption from Arbitration. 18 **Del.C.** §§3349(b) and 3565(b) shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On a quarterly basis, each carrier shall provide a list of ~~non~~ exempt plan numbers to the Department. The Department shall maintain a public register of ~~such non~~ exempt plan numbers. The placement of an ~~non~~ exempt plan number on the register shall constitute a rebuttable presumption that ~~such non-exempt~~ the policy plan ~~number~~ is not subject to the provisions of this regulation. A carrier that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this ~~sub~~ section but only with respect to the plans for which such identification or membership cards display the group status. The failure of a carrier to either (1) provide the Department with a list of exempt plan numbers, or (2) clearly identify if a plan is exempt or non-exempt on the face of an identification or membership card shall constitute a rebuttable presumption that the plan is subject to the provisions of this regulation.

5.5 A carrier and a non-network emergency care provider can mutually agree in writing to submit to arbitration pursuant to Section 7.0 payment disputes relating to the delivery of emergency care services to patients covered by a plan otherwise exempt from arbitration, except that such agreement will only apply to the plan and the services stated therein.

5.~~5~~6 The provisions of this regulation shall not apply to Medicaid or any other health insurance program where the review of coverage determinations is otherwise regulated by the provisions of other state or federal laws or regulations.

6.0 Arbitration Procedure to Review a Carrier's Final Coverage Decision

6.1 Petition for Arbitration

6.1.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through arbitration by delivering a Petition for Arbitration to the Department so that it is received by the Department no later than 60 days after the covered person's receipt of written notice of the carrier's final coverage decision.

6.1.2 A covered person or his authorized representative must deliver to the Department an original and three copies of the Petition for Arbitration.

6.1.3 At the time of delivering the Petition for Arbitration to the Department, a covered person or his authorized representative must also:

6.1.3.1 send a copy of the Petition to the carrier by certified mail, return receipt requested;

6.1.3.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the carrier by certified mail, return receipt requested; and

6.1.3.3 deliver to the Department a non-refundable $75.00 filing fee.

6.1.4 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration. If the subject of the Petition is appropriate for review through IHCAP, the Department shall advise the covered person or his authorized representative of the procedure to obtain IHCAP review. If the subject of the Petition is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal for purposes of determining whether the IHCAP appeal is timely filed in accordance with section 8.1 of this regulation.

6.2 Response to Petition for Arbitration

6.2.1 Within 20 days of receipt of the Petition, the carrier must deliver to the Department an original and three copies of a Response with supporting documents or other evidence attached.

6.2.2 At the time of delivering the Response to the Department, the carrier must also:

6.2.2.1 send a copy of the Response and supporting documentation to the covered person or his authorized representative by first class U.S. mail, postage prepaid; and

6.2.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the covered person or his authorized representative.

6.2.3 The Department may return any non-conforming Response to the carrier.

6.2.4 If the carrier fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

6.2.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the carrier.

6.2.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

6.3 Summary Dismissal of Petition by the Department

6.3.1 If the Department determines that the subject of the Petition is not appropriate for arbitration or IHCAP or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

6.4 Appointment of Arbitrator

6.4.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

6.4.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the provider whose service is at issue in the dispute.

6.5 Arbitration Hearing

6.5.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

6.5.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

6.5.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

6.5.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

6.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed unless otherwise agreed by the parties.

6.5.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

6.5.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

6.6 Arbitrator's Written Decision.

6.6.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

6.6.2 The Arbitrator's decision is binding upon the carrier except as provided in 18 **Del.C.** §332(g).

6.7 Arbitration Costs.

6.7.1 In arbitrations commenced under 18 **Del.C.** §332 and this Section 6.0, the carrier shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of $75.00 required to commence arbitration.

~~6.7.2 In arbitrations commenced under 18 **Del.C.** §§3349 or 3565, the non-prevailing party(ies) shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of $75.00 required to commence arbitration.~~

7.0 ~~Special~~ Provisions Applicable to Arbitration Pursuant to 18 Del.C. §§3349 and 3565

~~7.1 In any arbitration pursuant to 18 **Del.C.** §§3349 or 3565, the Arbitrator shall, at a minimum, receive evidence relating to the following items:~~

~~7.1.1 The highest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~7.1.2 The lowest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~7.1.3 The highest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~7.1.4 The lowest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~7.1.5 The number of times during the preceding twelve months that the carrier experienced a dispute or disagreement with respect to the payment for the particular service in a comparable medical facility where the service was provided, and the outcome of such disputes or disagreements.~~

~~7.2 The information specified in section 7.1 of this regulation and provided to the Arbitrator shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.~~

~~7.3 The Arbitrator shall consider the following guidelines as a basis for determining the rate or charge for a disputed service unless the evidence adduced at arbitration requires a determination on a different basis:~~

~~7.3.1 *Payments for emergency services to a non network emergency care provider who was a network emergency care provider at any time prior to the date the provider delivered the emergency care services which are the subject of the arbitration*. A carrier shall pay such non-network emergency care provider the higher of either (1) the highest contract rate for the services provided during the~~

~~term of the provider's contract with the insurer, subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time, or (2) the highest undisputed amount regularly paid by any network insurer to the non-network provider for performance of the same service. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.~~

~~7.3.2 *Other payments for emergency care services with CPT codes*. A carrier shall pay non-network emergency care providers who were never network providers with the carrier an amount equal to the lesser of the non-network emergency care provider billed fee for such service or the highest negotiated rate between the carrier and any network provider for the service based on the appropriate CPT code until such time as the non-network provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.~~

~~7.3.3 *Payments for emergency care services without CPT codes.* For emergency care services that do not have a CPT code or other identifiable code number, a carrier shall pay non-network emergency care providers the lesser of the non-network emergency care provider billed fee, or the highest negotiated network rate received by the non-network provider from any carrier for the performance of the same service. When and if the non-network provider becomes a network provider, payments will be based on the negotiated rate.~~

~~7.3.4 Changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this section to payments for emergency care services. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.~~

~~7.4 *Duty to Arbitrate*. Every carrier and provider shall submit to arbitration pursuant to this Section 7.0 all fee disputes arising from the provision of emergency care services under 18 **Del.C.** §3349 and 3565, except as provided in Section 5.4.~~

7.1 If a carrier and a non-network emergency care provider can not agree on payment to the provider for emergency care services, within 30 days after the carrier has received from the provider clean claims, as defined in Section 4.0 of Regulation 1310, for such services, either the carrier or the non-network emergency care provider (the "Petitioner") may petition for arbitration pursuant to this Section 7.0 and 18 **Del.C.** §§3349 or 3565 and the other party (the "Respondent") shall submit to such arbitration.

7.2 Prior to the Arbitration Hearing, the Arbitrator shall at a minimum receive the following written evidence from the parties:

7.2.1 The highest allowable charge for each emergency care service subject to arbitration allowed by the carrier for any other network or non-network emergency care provider during the full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department;

7.2.2 If Section 7.4.1 applies, the carrier's highest allowable charge for each emergency care service subject to arbitration pursuant to the non-network provider's most recent participation agreement with the carrier;

7.2.3 The highest allowable charge for each emergency care service subject to arbitration received by the non-network emergency care provider from any other carrier during a full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department; and

7.2.4 The highest allowable charge for each emergency care service subject to arbitration received by the non-network emergency care provider from any network carrier during a full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department.

7.2.5 Each party shall also submit in writing the allowable charge each party would accept for each emergency care service subject to arbitration and each party's history of the negotiations between the parties relating to each such emergency care service.

7.2.6 Each party shall also submit a written list of all emergency care services subject to arbitration and the date each service was delivered to the patient. The Arbitrator's decision shall apply to each such service from the date of each service and the date of all other emergency care service subject to arbitration through the date provided for in Section 7.12.2.

7.2.7 A copy of all information submitted to the Arbitrator by a party pursuant to this Section 7.0 will also be given to the other party except for information submitted by the provider pursuant to Sections 7.2.3 and 7.2.4. Section 7.2.3 and Section 7.2.4 information will be redacted by the Arbitrator and given to the carrier to insure that the carrier can not determine pricing information relating specifically to other carriers.

7.3 All information specified in Section 7.2 of this Regulation provided to the Arbitrator shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.

7.4 The Arbitrator shall follow the guidelines listed in this Section 7.4 as a basis for determining the carrier's payment to the non-network emergency care provider for each emergency care service subject to arbitration unless the evidence adduced at arbitration supports a different payment.

7.4.1 Payments for emergency care services to a non-network emergency care provider who was a network emergency care provider at any time prior to the date the provider delivered the emergency care services which are the subject of the arbitration. The Arbitrator shall direct the carrier to pay the non-network emergency care provider based on an allowable charge for each emergency care service subject to arbitration within the following range: (1) the allowable charges submitted to the Arbitrator pursuant to Section 7.2.2, subject to COLA adjustments as may be published in bulletins by the Commissioners from time to time; and (2) the allowable charges submitted to the Arbitrator pursuant to Section 7.2.3. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.

7.4.2 Payments for emergency care services to a provider who was never a network emergency care provider with the carrier. The Arbitrator shall direct the carrier to pay the non-network emergency care provider who was never a network emergency care provider based on an allowable charge for each emergency care service subject to arbitration within the following range: (1) the allowable charges submitted to the carrier pursuant to Section 7.2.1; and (2) the allowable charges submitted to the Arbitrator pursuant to Section 7.2.3. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.

7.5 Changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this Section 7.0. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.

7.6 Carrier Payments Prior to Arbitration.

7.6.1 Prior to Arbitrator's decision pursuant to Section 7.12, the carrier will pay directly to the non-network emergency care provider the highest amount provided for in Section 7.2.1 for each emergency care service subject to arbitration.

7.6.2 All payments due the non-network provider pursuant to Section 7.6.1 will be paid within 30 days after the carrier has received from the provider a clean claim, as defined in Section 4.0 of Regulation 1310, for each emergency care service subject to arbitration.

7.6.3 The Arbitrator will direct the carrier and the provider to pay, in the case of the carrier, or refund in the case of the provider, the difference between payments made pursuant to this Section 7.6 and the payments determined by the Arbitrator pursuant to Section 7.4.

7.7 Procedures for Arbitration Pursuant to this Section 7.0.

7.7.1 Either the non-network emergency care provider or his authorized representative or the carrier, after the carrier pays the provider pursuant to Section 7.6.1, may request arbitration by delivering to the Department an original and three copies of the Petition for Arbitration, (with all applicable information required by Section 7.2 attached) so that the Petition is received by the Department no later than 60 days from the date the carrier was required to pay the provider pursuant to Section 7.6.1.

7.7.2 At the time of delivering the Petition for Arbitration to the Department. the Petitioner or his authorized representative must also:

7.7.2.1 send a copy of the Petition to the Respondent by certified mail, return receipt requested;

7.7.2.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the Respondent by certified mail, return receipt requested; and

7.7.2.3 deliver to the Department a $75.00 filing fee.

7.8 Response to Petition for Arbitration

7.8.1 Within 20 days of receipt of the Petition, the Respondent or his authorized representative must deliver to the Department an original and three copies of a Response with all information required by Section 7.2 attached.

7.8.2 At the time of delivering the Response to the Department, the Respondent must also:

7.8.2.1 send a copy of the Response and supporting documentation to the Petitioner or his authorized representative by first class U.S. mail, postage prepaid; and

7.8.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the Petition or his authorized representative.

7.8.3 The Department may return any non-conforming Response to Respondent.

7.8.4 If the Respondent fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

7.8.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the Respondent.

7.8.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

7.9 Summary Dismissal of Petition by the Department

7.9.1 If the Department determines that the subject of the Petition is not appropriate for arbitration, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

7.10 Appointment of Arbitrator

7.10.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

7.10.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties.

7.11 Arbitration Hearing

7.11.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

7.11.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

7.11.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

7.11.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

7.11.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed.

7.11.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

7.11.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this Section 7.0. The Arbitrator shall not

consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

7.12 Arbitrator's Written Decision.

7.12.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

7.12.2 The Arbitrator's decision is binding upon the parties with respect to allowable charges and payments for each emergency care service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

7.13 Arbitration Costs.

7.13.1 In arbitrations commenced pursuant to 18 **Del.C.** §§3349 or 3565, the arbitrator shall allocate to each party a percentage of the costs of arbitration, including the filing fee of $75.00 required to commence arbitration, except that costs shall not include any professional fees, except the arbitrator's fee.

7.14 The provision of this Section 7 supersedes the provisions of Regulation 1313.

8.0 IHCAP Procedure

8.1 A covered person or his authorized representative may request review of a final coverage decision based on medical necessity or appropriateness of services by filing an appeal with the carrier within 60 days of receipt of the final coverage decision.

8.2 Upon receipt of an appeal, the carrier shall transmit the appeal electronically or by facsimile to the Department as soon as possible, but within no more than three business days, and shall send a hard copy of the request to the Department by mail.

8.3 Within five calendar days of receipt of an appeal, the Department shall assign an approved, impartial Independent Utilization Review Organization to review the final coverage decision and shall notify the carrier.

8.4 The assigned IURO shall, within five calendar days of assignment, notify the covered person or his authorized representative in writing by certified or registered mail that the appeal has been accepted for external review.

8.4.1 The notice shall include a provision stating that the covered person or his authorized representative may submit additional written information and supporting documentation that the IURO shall consider when conducting the external review.

8.4.2 The covered person or his authorized representative shall submit such written documentation to the IURO within seven calendar days following the date of receipt of the notice.

8.4.3 Upon receipt of any information submitted by the covered person or his authorized representative, the assigned IURO shall as soon as possible, but within no more than two business days, forward the information to the carrier.

8.4.4 The IURO must accept additional documentation submitted by the carrier in response to additional written information and supporting documentation from the covered person or his authorized representative.

8.5 Within seven calendar days after the receipt of the notification required in section 8.3, the carrier shall provide to the assigned IURO the documents and any information considered in making the final coverage decision.

8.5.1 If the carrier fails to submit documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the final coverage decision.

8.6 The external review may be terminated if the carrier decides to reverse its final coverage decision and provide coverage or payment for the health care service that is the subject of the appeal.

8.6.1 Immediately upon making the decision to reverse its final coverage decision, the carrier shall notify the covered person or his authorized representative, the assigned IURO, and the Department in

writing of its decision. The assigned IURO shall terminate the external review upon receipt of the written notice from the carrier.

8.7 Within 45 days after the IURO's receipt of an appeal, the assigned IURO shall provide written notice of its decision to uphold or reverse the final coverage decision to the covered person or his authorized representative, the carrier and the Department, which notice shall include the following information:

8.7.1 the qualifications of the members of the review panel;

8.7.2 a general description of the reason for the request for external review;

8.7.3 the date the IURO received the assignment from the Department to conduct the external review;

8.7.4 the date(s) the external review was conducted;

8.7.5 the date of its decision;

8.7.6 the principal reason(s) for its decision; and

8.7.7 references to the evidence or documentation, including practice guidelines and clinical review criteria, considered in reaching its decision.

8.8 The decision of the IURO is binding upon the carrier except as provided in 18 **Del.C.** §6416(b).

9.0 Expedited IHCAP Procedure

9.1 A covered person or his authorized representative may request an expedited appeal at the time the carrier issues its final coverage decision if the covered person suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

9.2 At the time the carrier receives request for an expedited appeal, the carrier shall immediately transmit the appeal electronically or by facsimile to the Department and shall send a hard copy to the Department by mail.

9.3 If the Department determines that the review meets the criteria for expedited review, the Department shall assign an approved, impartial IURO to conduct the external review and shall notify the carrier.

9.4 At the time the carrier receives the notification of the assigned IURO, the carrier shall provide or transmit all necessary documents and information considered in making its final coverage decision to the assigned IURO electronically, by telephone, by facsimile or any other available expeditious method.

9.5 As expeditiously as the covered person's medical condition permits or circumstances require, but in no event more than 72 hours after the IURO's receipt of the expedited appeal, the IURO shall make a decision to uphold or reverse the final coverage decision and immediately notify the covered person or his authorized representative, the carrier, and the Department of the decision.

9.6 Within two calendar days of the immediate notification, the assigned IURO shall provide written confirmation of its decision to the covered person or his authorized representative, the carrier, and the Department.

9.7 The decision of the IURO is binding upon the carrier except as provided in 18 **Del.C.** §6416(b).

10.0 Refusal or Dismissal of IHCAP Appeal

10.1 The Department may refuse to accept any appeal that is not timely filed or does not otherwise meet the criteria for IHCAP review. If the subject of the appeal is appropriate for arbitration, the Department shall advise the covered person or his authorized representative of the arbitration procedure. If the subject of the appeal is appropriate for arbitration, the appeal shall be treated as a Petition for Arbitration for purposes of determining whether the Petition is timely filed in accordance with section 6.1.1 of this regulation.

10.2 Carrier's motion to dismiss an IHCAP appeal.

10.2.1 A carrier may move to dismiss an IHCAP appeal if the carrier believes:

10.2.1.1 the appeal concerns a benefit that is the subject of an express written exclusion from the covered person's health insurance;

10.2.1.2 the appeal is appropriate for arbitration; or

10.2.1.3 the appeal should be dismissed because it is inappropriate for IHCAP review as explained in a sworn statement by an officer of the carrier.

10.2.2 The carrier's motion to dismiss must be made in writing at the time the carrier transmits the appeal to the Department and must include any necessary supporting documentation.

10.2.3 The Department shall review the appeal and motion for dismissal and may, in its discretion:

10.2.3.1 dismiss the appeal and notify the covered person or his authorized representative in writing that the appeal is inappropriate for the IHCAP; or

10.2.3.2 appoint an IURO to conduct a full external review.

11.0 IHCAP Costs

11.1 All costs for IHCAP review by an IURO, whether the review is preliminary, or partially or fully completed, shall be borne by the carrier.

11.2 The carrier shall reimburse the Department for the cost of the IHCAP review within 90 calendar days of receipt of the decision by the IURO or within 90 days of termination of review by the IURO by other means.

12.0 Approval of Independent Utilization Review Organizations

12.1 The Department shall approve IUROs eligible to be assigned to conduct IHCAP reviews as provided in 18 **Del.C.** §6417(a).

12.2 An IURO seeking approval to conduct IHCAP reviews shall submit an application to the Department that includes the information required by 18 **Del.C.** §§6417(c)(1), 6417(c)(2), 6417(c)(4) and 6417(c)(4)(d).

12.3 The Department shall maintain a current list of approved IUROs.

13.0 Carrier Recordkeeping and Reporting Requirements

13.1 A carrier shall maintain written or electronic records documenting all grievances, Petitions for Arbitration and appeals for IHCAP review including, at a minimum, the following information:

13.1.1 For each grievance:

13.1.1.1 the date received;

13.1.1.2 name and plan identification number of the covered person on whose behalf the grievance was filed;

13.1.1.3 a general description of the reason for the grievance; and

13.1.1.4 the date and description of the final coverage decision.

13.1.2 For each Petition for Arbitration:

13.1.2.1 the date the Petition was filed;

13.1.2.2 name and plan identification number of the covered person on whose behalf the Petition was filed;

13.1.2.3 a general description of the reason for the Petition; and

13.1.2.4 date and description of the Arbitrator's decision or other disposition of the Petition.

13.1.3 For each appeal for IHCAP review:

13.1.3.1 the date received;

13.1.3.2 name and plan identification number of the covered person on whose behalf the appeal was filed;

13.1.3.3 a general description of the reason for the appeal; and

13.1.3.4 date and description of the IURO's decision or other disposition of the appeal.

13.2 A carrier shall file with its annual report to the Department the following information:

13.2.1 The total number grievances filed.

13.2.2 The total number of Petitions for Arbitration filed, with a breakdown showing:

13.2.2.1 the total number of final coverage decisions upheld through arbitration; and

13.2.2.2 the total number of final coverage decisions reversed through arbitration.

13.2.3 The total number of IHCAP appeals filed, with a breakdown showing:

13.2.3.1 the total number of final coverage decisions upheld through IHCAP; and

13.2.3.2 the total number of final coverage decisions reversed through IHCAP.

13.3 A carrier shall make available to the Department upon request any of the information specified in the foregoing sections 13.1 and 13.2, and other information regarding its internal review process including but not limited to the written IRP procedures and forms the carrier distributes to covered persons.

14.0 Non-Retaliation

14.1 A carrier shall not disenroll, terminate or in any way penalize a covered person who exercises his rights to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

14.2 A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises, on behalf of a covered person, the right to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

15.0 Confidentiality of Health Information

15.1 Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

16.0 Effective Date

16.1 This regulation shall become effective on July 11, 2007

11 DE Reg. 68 (07/01/07)

12 DE Reg. 974 (01/01/09) (Final)