PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT (EXCERPT)
Act 251 of 2000

550.1903 Definitions.

Sec. 3. As used in this act:

(a) "Adverse determination" 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 that is a covered benefit has been reviewed and, based on the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination is an adverse determination.

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

(c) "Authorized representative" means any of the following:

(*i*) A person to whom a covered person has given express written consent to represent the covered person in an external review.

(*ii*) A person authorized by law to provide substituted consent for a covered person.

(*iii*) If the covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional.

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

(e) "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.

(f) "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.

(g) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

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

(i) "Covered person" means a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan.

(j) "Department" means the department of insurance and financial services.

(k) "Director" means the director of the department.

(*l*) "Discharge planning" means the formal process for determining, before discharge from a facility, the coordination and management of the care that a patient receives following discharge from the 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) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(o) "Expedited internal grievance" means an expedited grievance under section 2213(1)(*l*) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

(p) "Facility" or "health facility" means:

(*i*) A facility or agency or a part of a facility or agency that is licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e.

(*ii*) A psychiatric hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities operated by the department of health and human services or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a freestanding hemodialysis unit.

(*v*) An ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance use disorder services program licensed under part 62 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(q) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in section 2213 of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or sections 404 or 407 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404 and MCL 550.1407.

(r) "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 covered health care services.

(s) "Health care professional" means an individual licensed, certified, registered, or otherwise authorized to engage in a health profession under parts 161 to 183 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18315.

(t) "Health care provider" or "provider" means a health care professional or a health facility.

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

(v) "Health carrier" means a person that is subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit health care corporation, a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, or any other person providing a plan of health insurance, health benefits, or health services. Health carrier does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(w) "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 or more of the following:

(*i*) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.

(*ii*) The provision of health care services to an individual.

(*iii*) Payment for the provision of health care services to an individual.

(x) "Independent review organization" means a person that conducts independent external reviews of adverse determinations.

(y) "Medical or scientific evidence" means evidence found in any of the following sources:

(*i*) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(*ii*) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's United States National Library of Medicine for indexing in the former Index Medicus or its current online version, MEDLINE, and Elsevier B. V. for indexing in EMBASE.

(*iii*) Medical journals recognized by the secretary of the United States Department of Health and Human Services under 42 USC 1395x(t)(2)(B)(ii)(I).

(*iv*) The following standard reference compendia:

(A) The American Hospital Formulary Service drug information.

(B) Drug facts and comparisons.

(C) The American Dental Association's accepted dental therapeutics.

(D) The United States Pharmacopoeia drug information.

(*v*) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the following:

(A) The Agency for Healthcare Research and Quality.

(B) The National Institutes of Health.

(C) The National Cancer Institute.

(D) The National Academy of Sciences.

(E) The Centers for Medicare and Medicaid Services.

(F) The United States Food and Drug Administration.

(G) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.

(*vi*) Any other medical or scientific evidence that is comparable to the sources listed in subparagraphs (*i*) to (*v*).

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

(aa) "Prospective review" means utilization review conducted before an admission or a course of treatment.

(bb) "Protected health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(cc) "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.

(dd) "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.

(ee) "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 may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

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

History: 2000, Act 251, Eff. Oct. 1, 2000;—Am. 2006, Act 542, Imd. Eff. Dec. 29, 2006;—Am. 2016, Act 274, Eff. Sept. 29, 2016.