Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 **Del.C.** §§311, 332 and 6401 *et seq.*)
18 **DE Admin. Code** 1301

EMERGENCY

EMERGENCY ORDER

Pursuant to 29 **Del.C.** §10119, it is necessary to promulgate an amendment to Regulation 1301 relating to Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims.

REASONS FOR EMERGENCY ACTION

A. On July 6, 2006, Senate Bill 295 was enacted as 75 *Del. Laws* 362 transferring regulatory oversight of managed care organizations to the Department of Insurance ("Department") from the Department of Health and Social Services. Sections 3 and 6 of the act provided for full implementation of the act by January 6, 2007.

B. The transfer of regulatory authority created the need for substantial revisions to existing regulations currently in force as well as the need to make significant changes to the case handling system for medical insurance claims, reviews and arbitrations within the Department.

C. The Department was not able to complete the process of amending the existing regulations, including the requirement to meet the publication and public notice provisions of the Delaware Administrative Procedures Act within the prescribed time limit.

D. If an emergency regulation is not adopted, there is the potential that numerous claims will not be able to have the statutory review allowed by Delaware law and that Delaware citizens will be at risk of having benefits delayed or denied because there is no regulatory guidance to fill the gap as a result of the transfer of regulatory authority to the Department.

E. The Department has completed the work necessary to submit the proposed amended regulations for public comment and by issuing this emergency order will permit a timely transition for the review of medical claims during the time required for public comment on the proposed regulatory amendments.

F. On January 8, 2007, I issued an Emergency Order adopting revisions to Regulation 1301. As a result of public comment received in response to the proposed revisions as published in the February 1, 2007 Register of Regulations, it is necessary to rescind the order of January 8, 2007 and substitute in lieu thereof, a new Emergency Order placing into effect revisions to Regulation 1301 based on the public comment received by the Department of Insurance.

DECISION AND ORDER

1. Regulation 1301 as currently promulgated as an emergency regulation is rescinded and the attached revised version of Regulation 1301 is substituted in lieu thereof as a new emergency regulation effective March 15, 2007.

2. This order shall be effective until July 15, 2007 or until the attached amendment to Regulation 1301 is adopted pursuant to the Delaware Administrative Procedures Act whichever shall first occur. The Department will receive, consider and respond to petitions by any interested person for the reconsideration or revision of the emergency regulation.

3. The Department gives public notice of the proposed amendment to Regulation 1301 as required by 29 **Del.C**. § 10115 as follows:

PUBLIC NOTICE OF PROPOSED DEPARTMENT OF INSURANCE REGULATION RELATING TO INTERNAL REVIEW, ARBITRATION AND INDEPENDENT UTILIZATION REVIEW OF HEALTH INSURANCE CLAIMS

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed amendments to Department of Insurance **Regulation 1301** relating to **Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims**. The docket number for this proposed regulation is 356.

The Department of Insurance proposes to amend Regulation 1301 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2006, it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The Delaware Code authority for the change is 18 **Del.C.** §§311, 332 and 6401 *et seq*. The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., Wednesday, May 2, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

4. Since the wording of the attached emergency regulation is identical to the wording the Department intends to adopt as a final regulation, public comment on the emergency regulation shall be deemed to be public comment on the proposed regulation as would otherwise be permitted under 29 **Del.C.** §10115.

IT IS SO ORDERED this 15th day of March, 2007

Matthew Denn
Insurance Commissioner

~~1301 Arbitration of Health Insurance Claims and Internal Review Process of Medical Insurance Carriers~~

~~1.0 Purpose and Statutory Authority~~

~~The purpose of this Regulation is to implement 16 **Del.C.** §9119, 18 **Del.C.** §§332, 3348, 3559E, and 18 **Del.C.** Ch. 23 by establishing the procedures for the arbitration of certain claims for benefits available under health insurance policies or agreements, and/or the explicit provisions of the statutes under which this regulation is promulgated. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 2312, and 29 **Del.C.** Ch. 101 and 73 **Del. Laws** Ch. 96. This Regulation should not be construed to create any cause of action not otherwise existing at law.~~

~~2.0 Definitions~~

~~2.1 Except as otherwise noted, the following definitions shall apply:~~

~~**"Commissioner"** shall mean the Insurance Commissioner of Delaware.~~

~~**"Department"** shall mean the Delaware Insurance Department.~~

~~**"Emergency care service"** shall have the same meaning as contained in 18 **Del.C.** 3348(c) and 3559E and include:~~

~~• 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~~

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

~~**"Emergency medical condition"** shall have the meaning assigned to it by 18 **Del.C.** §§3348(d) and 3559E(d).~~

~~**"Health insurance policy"** shall have the meaning assigned to it by 18 **Del.C.** §332(a)8.~~

"Insured" shall, in addition to its ordinary meaning, include the participants, subscribers or members of such health plans, health service corporations, medical care organizations or health maintenance organizations.

"Insurer" or **"carrier,"** in addition to its ordinary meaning under 18 **Del.C.** §3343(a)(1), includes health plans, health service corporations, medical care organizations and health maintenance organizations subject to state insurance regulation.

"IRP" shall mean an internal review process established by an insurer under 18 **Del.C.** §332.

"Network insurer" is an insurer who has a written participation agreement with the provider to pay for emergency care services in Delaware on and after January 1, 2002.

"Network provider" is a provider who has a written participation agreement with the insurer to provide emergency care services in Delaware as of the date those services were provided. All other providers of emergency care services shall be considered non-network providers.

"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 an emergency care service in this State after January 1, 2002.

3.0 Insurer's Duty to Arbitrate

3.1 Except for claims exempt from arbitration by law or regulation, every insurer, carrier, provider, network provider and non-network provider giving or providing health and/or emergency medical services, and/or health insurance coverage or benefits in this State shall be subject to arbitration as follows:

3.1.1 For covered claims arising from the provision of emergency services under 18 **Del.C.** §§3348 and 3559E; and

3.1.2 For appeals from decisions of an IRP under 18 **Del.C.** §332 by the insured.

4.0 Exemption from Arbitration

4.1 Health claims or appeals which involve issues of medical necessity and/or the appropriateness of services, as defined in 16 **Del.C.** §9119, shall be exempt from arbitration by the Department. Any claims or appeals arising under 16 **Del.C.** §9119 and filed with the Department shall be deemed properly filed if actually received by the Department within in the allotted statutory time and such appeals shall, within 7 days from the date the Department determines that such appeals are exempt or excluded from arbitration, be forwarded by the Department through normal state channels to the Department of Health and Social Services, or its appropriate successor agency, for external under 16 **Del.C.** §9119 and such other laws and regulations as are applicable to said claims or appeals.

4.2 18 **Del.C.** §§3348 and 3559E shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On or before July 1, 2002, and quarterly thereafter, each insurer shall provide a list of non-exempt plan numbers, as defined in 18 **Del.C.** §§3348 and 3559E to the Department. The Department shall maintain a public register of such non-exempt plan numbers. The placement of a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is subject to the provisions of this regulation. An insurer 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.

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

5.0 Exclusion from Arbitration

5.1 The following claims shall not be subject to arbitration under this regulation:

5.1.1 Claims for which there is no jurisdiction under 18 **Del.C.** §332.

5.1.2 Claims that are already pending before any court or other administrative agency; or

5.1.3 Claims that have been exempted by the Commissioner under section 4.0 of this regulation.

5.2 The Arbitration Secretary or Arbitrator is authorized to dismiss a matter upon receipt of information sufficient to establish that the claim is excluded under section 5.1 and after notice and an opportunity to respond is provided the claimant.

6.0 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 insurers subject to state jurisdiction offering health coverage in Delaware:

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

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

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

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

6.1.4 White space separating subjects or sections should be distinct;

6.1.5 There must be included a table of contents sufficient to guide and assist the insured;

6.1.6 Where appropriate definitions shall be included and shall be sufficient to clearly apply to the usage intended.

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

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

6.2 All forms relating to grievances, appeals, or other procedures relating to the IRP shall be provided as examples along with the written IRP provided to the insured by the insurer.

6.3 The first notice of an IRP shall be given to all participants of an insurer within thirty (30) days of approval by the Commissioner. The annual notice thereafter shall either be upon the policy renewal date, open enrollment date, or a set date for all insureds or participants of the insurer, at the insurer's discretion. For every new policy issued after the approval of the IRP by the Commissioner, the insurer shall provide a copy of the IRP at the time, or prior to the time, the insurer sends identification cards, members handbooks or similar member materials to newly insured participants. When the insured's dependents reside in the same household as the insured, a single notice to the principal insured shall be sufficient under this section.

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

7.0 Mediation Services

7.1 At the time the insurer provides a written notice of an unfavorable disposition of a claim or grievance to an insured, the insurer shall provide the insured with a written notice of mediation services offered by the Delaware Insurance Department. Such notice may be separate from or a part of the written notice of disposition of a claim or grievance. Any notice provided to an insured shall, at a minimum, contain the following information:

> You have the right to appeal a claim denial for medical reasons to the Delaware Department of Health and Social Services or to appeal a claim denial for non-medical reasons to 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 appeal this decision. You can contact the Delaware Insurance Department for information about an appeal 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 appeal or mediation process. All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

8.0 Payments for Emergencies Based on Date of Service

8.1 Under 18 **Del.C.** §§3348 and 3559E the Commissioner shall be responsible for setting rates and charges in the event of a dispute between an insurer and a provided. In an arbitration pursuant to said statutes,

the Arbitrator shall consider the following guidelines as a basis for determining the rate or charge for a disputed service unless the evidence adduced under section 9.5 at arbitration requires a determination on a different basis.

8.2 Payments for existing emergency care services as of July 1, 2002. Effective on July 1, 2002, under circumstances where the contract between the provider and insurer was terminated after January 1, 2002, insurers will pay such provider the highest contract rate for the services provided during the term of the contract for services identified in 18 **Del.C.** §§3348 or 3559E, adjusted annually to reflect changes in payments by that insurer to its network providers and subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time. Effective on July 1, 2002, insurers will pay non-network providers who were not network providers on or after January 1, 2002 the higher of either (1) the highest payment rate paid by the insurer to the non-network provider for performance of the same service; 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.

8.3 Payments for new emergency care services after July 1, 2002. Each insurer shall pay non-network providers for each emergency medical care service after July 1, 2002, an amount equal to the lesser of the non-network provider billed fee for such new service or the highest negotiated rate between the insurer and any network provider for the service based on the appropriate CPT code until such time as the provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.

8.3 Payments for new emergency care services that receive CPT codes on or after July 1, 2002. Effective on or after July 1, 2002, for services that do not have a CPT code or other identifiable code number, each insurer shall pay non-network providers the lesser of: the provider billed fee, or the highest negotiated network rate received by the provider from any insurer for the performance of the same service. When and if the provider becomes a network provider with insurer, payments will be based on the negotiated rate.

8.4 Subsequent to January 1, 2002, 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 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.

9.0 General Procedures Applicable to Arbitrations

9.1 In arbitration proceedings and practice, the person(s), firm(s) or entity(ies) who initiates the proceeding by filing a petition for arbitration of a disputed claim or issue with the Commissioner shall be known as the "claimant(s)," and the person(s), firm(s) or entity(ies) against whom such claim or claims is asserted shall be known as "respondent(s)."

9.2 A petition for arbitration shall be in writing and filed in the office of the Commissioner on or before the sixtieth day following the claimant's receipt of the written adverse determination or denial.

9.3 The parties must provide a brief statement certifying the service of all filed papers with the manner, date and address of service. A certification of service using Form C in the appendix to this Regulation shall be satisfactory if mailed to the opposing party as required by this Regulation.

9.4 Notice and Manner of Service.

9.4.1 Notice and manner of service, except service of the original petition, is sufficient and complete if properly addressed, upon mailing the same with prepaid first class U.S. Postage.

9.4.2 Service of an original petition shall be by Certified U.S. Postage and Return receipt requested or hand delivery to the respondent and is complete upon receipt by addressee or an employee in respondent's place of business.

9.5 In any arbitration pursuant to 18 **Del.C.** §§3348 or 3559E, the Arbitrator shall, at a minimum, receive evidence relating to the following items:

9.5.1 The highest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

9.5.2 The lowest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

9.5.3 The highest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

9.5.4 The lowest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

9.5.5 The number of times during the preceding twelve months that the insurer 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.

9.5.6 Such information as may be provided to the Arbitrator pursuant to an arbitration 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. Likewise, any personal health information introduced into evidence as part of the arbitration shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.

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

9.7 In arbitrations commenced under 18 **Del.C.** §§3348 or 3559E, 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.

10.0 Commencement of Arbitration

10.1 An arbitration will commence upon the filing of an original and three copies of a petition, in acceptable form with the Commissioner's Arbitration Secretary with the supporting documents or other evidence attached thereto and payment of the non-refundable filing fee of $75.00. The claimant shall, at the same time, send a copy of the petition and supporting documents to the respondent as required in section 9.0. The Arbitration Secretary may refuse to accept any petition which fails to meet the jurisdictional requirements for arbitration. The failure to file a petition which meets the jurisdictional requirements for arbitration shall not toll the time allowed to file for arbitration.

10.2 Within 20 days of receipt of the petition, the respondent shall file an original and three copies of a response, in acceptable form, with the Arbitration Secretary with supporting documents or other evidence attached. The respondent shall, at the same time, send a copy of the response and supporting documents to the claimant as required in section 9.0. The Arbitration Secretary may return any non-conforming response. If the Arbitration Secretary or Arbitrator determines at any time that the petition fails to meet the jurisdictional requirements of the statute or this regulation or is meritless on its face, the petition may be summarily dismissed by the Arbitration Secretary or Arbitrator and notice of such dismissal shall be provided to the parties. The non-prevailing party may seek to have the petition re-opened under the provisions of 10.3 of this section.

10.3 If the respondent fails to file a response in a timely fashion, the Arbitration Secretary after verifying proper service and notice to the parties may assign the matter to the next scheduled Arbitrator for summary disposition. 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 respondent. The Arbitration Secretary or 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 5 business days after notice of the default judgment.

10.4 Upon the filing of a proper response, the Arbitration Secretary shall assign and schedule the matter for a hearing before an Arbitrator.

11.0 Arbitration

The Commissioner shall appoint a single arbitrator of suitable background and experience to hear any case presented for arbitration under this regulation. No arbitrator may be selected where the arbitrator's employer or client is a party. The Arbitrator shall act as the Commissioner's designee and shall issue a written opinion as required by 29 **Del.C.** §10126.

12.0 Arbitration Hearings

12.1 The arbitration hearing shall be scheduled and notice of the hearing shall be given the parties at least 10 business days prior to the hearing. Neither party is required to appear and may rely on the filed papers.

12.2 The purpose of Arbitration is an attempt to effect a prompt and inexpensive resolution of claims after reasonable attempts by the parties to resolve the matter. In keeping with that goal arbitration hearings shall be conducted in accordance with the provisions of the 29 **Del.C.** Ch. 101. The arbitration hearing is not a substitute for a civil trial. Accordingly, The Delaware Rules of Evidence will be used for general guidance but will not be strictly applied. Hearings are to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence in support of the pleading and to answer

questions by the Arbitrator. If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross examination or other response by the opposing party. Because the testimony may involve evidence relating to personal health information that is confidential and protected by other state or federal laws from public disclosure, the arbitration hearings shall be closed unless otherwise agreed by the parties.

12.3 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.

12.4 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 5 business days notice, except claims of a continuing nature which are set out in the filed papers.

12.5 The Arbitrator shall render his/her decision and mail a copy of the decision to the parties within 45 days of the filing of the petition. Upon mailing said decision, the time limits imposed by 29 **Del.C.** §10126 shall apply for the parties' review and execution of the order by the Commissioner.

13.0 Appeals

13.1 Appeals from the decision of the Commissioner shall be taken to the Superior Court of the State of Delaware by filing a copy of the Notice of Appeal, as filed in the Superior Court, with the Arbitration Secretary.

13.2 The Rules of Civil Procedure of the Superior Court shall govern all appeal procedures.

13.3 Any appeal which, as a matter of law, has to be filed in a court other than the Superior Court, shall be subject to the rules of such court and the appellant shall file a copy of the Notice of Appeal to such court with the Arbitration Secretary.

14.0 Confidentiality of Health Information

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

15.0 Effective Date

This regulation shall become effective on the 11 day of March, 2002.

Adopted And Signed By The Commissioner, February 15, 2002

Appendix
Regulation 1301 (Formerly Regulation 11) Form A
PETITION For Heatlh Insurance Arbitration

Your Name
_____
_____
Your Address
_____
_____
Your Telephone Number
_____
_____
Were You: _____Patient _____Spouse _____Parent or Guardian _____Power of Attorney _____Other

Name Of The Insurance Co. Against Which You Are Making A Claim
_____
_____
Case Number
_____
_____
Address _____
Telephone Number
_____
_____
Name Of The Policyholder If Other Than You _____
Address, If Different From Above _____
Date Of Determination Of Independent Review Process _____
Amount Of Your Claim

Dates Of Service (From)_____ (To)_____
Briefly Describe The Basis For Your Claim_____
_____
Prior To The Hearing, It Is Necessary That You Submit The Appropriate Documents To Support Your Petition To The Delaware Insurance Department And To The Opposing Party.

Parties May Present Witnesses In Their Behalf At The Hearing Provided That Due Notice Is Given. Please List The Name, Address And Telephone Number Of All Witnesses You Expect To Appear On Your Behalf On A Separate Sheet And Attach It To This Form.

If A settlement Has Been Offered To You, How Much Was It:_____

Who Will Represent You At The Hearing, If Applicable
Name _____
Address _____
Telephone _____

Under Delaware Law. Any Person Who Knowingly, And With Intent To Injure, Defraud, Or Deceive Any Insurer Who Files A Statement Or Claim Containing Any False, Incomplete, Or Misleading Information Is Guilty Of A Felony

Your Signature
_____date_____

Return The Original And Three Copies To: Delaware Insurance Department, 841 Silver Lake Boulevard, Dover, Delaware 19904

Regulation 1301 (Formerly Regulation 11) Form B
Response To Petition For Heatlh Insurance Arbitration

Case Number
_____
Claimant's Name
_____
Policyholder's Name (If Different From Claimant)
_____

Address (If Different From Claimant)
_____
_____
Respondent's Name
_____
Address _____
Telephone _____
If The Petition Relates To The Services Of An Individual Physician, Include The Following Information:
Physician's Name And Practice Group_____
Address _____
Telephone _____
PolicyNumber_____
Claim Number Assigned By Respondent
_____
Date Of Determination Of Independent Review Process_____
Amount Of Claim Admitted By Respondent_____

Dates Of Service
(From)_____(To) Briefly Describe The Basis For Your Response/objection To The Petition_____
_____
_____
_____

Prior To The Hearing, It Is Necessary That You Submit The Appropriate Documents To Support Your Petition To The Delaware Insurance Department And To The Opposing Party.

Parties May Present Witnesses In Their Behalf At The Hearing Provided That Due Notice Is Given. Please List The Name, Address And Telephone Number Of All Witnesses You Expect To Appear On Your Behalf On A Separate Sheet And Attach It To This Form.

If A Settlement Has Been Offered To You, How Much Was It:_____
Who Will Represent You At The Hearing
Name_____
Address _____
Telephone _____

Under Delaware Law. Any Person Who Knowingly, And With Intent To Injure, Defraud, Or Deceive Any Insurer Who Files A Statement Or Claim Containing Any False, Incomplete, Or Misleading Information Is Guilty Of A Felony

Your Signature_____date_____

Return The Original And Three Copies To: Delaware Insurance Department, 841 Silver Lake Boulevard, Dover, Delaware 19904

Regulation 11 form C
Proof Of Service Of Papers Required For Arbitrtation

I Certify That On The _____day Of _____. 20_____, In Addition To The Filing Provided To The Insurance Commissioner, I Sent A Copy Of The _____ Complaint For Arbitration With Required Attachments _____ Response To The Complaint For Arbitration With Required Attachments
Other
(Please Describe)_____
_____
To The Following Person(S) By Certified Mail, Return Receipt Requested:

Name _____
Address _____
Name _____
Address _____
_____
The Following Is Required By The Person Making This Certification
Name Of Party_____
Signature Of Party_____
Address Of Party _____
_____

Note: Save All Proofs Of Mailing And Return Receipt(S) For Verification By The Arbitrator.

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.

"**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. 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 medical 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 or dental 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 provider to pay for emergency care services in Delaware.

"**Network emergency care provider**" is an 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.

"**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 reside in the same household as the covered person, 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 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 a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is 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.

5.5 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

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, 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.

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 June 11, 2007. Pursuant to the orders of the Commissioner dated January 8, 2007 and March 15, 2007, any claim filed for review or arbitration after January 8, shall be governed by this regulation. Any claim filed for review or arbitration prior to January 8, 2007 under the version of this regulation adopted February 15, 2002 and not resolved prior to January 8, 2007 shall be governed by the February 15, 2002 version of this regulation.

10 DE Reg. 1485 (04/01/07) (Emer.)