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April 6, 2016

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Re: **Interpretive Opinion No. 01-16, Applicability of Utilization Review and External Review Procedures**

Dear Mr. White,

The Insurance Division ("Division") of the Tennessee Department of Commerce and Insurance is in receipt of the request for an interpretive opinion regarding the relation of procedures for utilization review under Tennessee Code Annotated ("Tenn. Code Ann.") § 56-6-705 and external review under Tenn. Code Ann. § 56-61-109. Specifically, you asked how the forty-eight (48) hour appeal timeframe provisions for utilization review under Tenn. Code Ann. § 56-6-705(a)(4)(C) works in conjunction with the seventy-two (72) hour appeal timeframe for external review under Tenn. Code Ann. § 56-61-109(f)(1).

As you noted, there are extensive similarities between the utilization review and external review statutes. Each section contemplates review of healthcare determinations with respect to medical necessity and appropriateness in the allocation of resources. *See* Tenn. Code Ann. §§ 56-6-702 (2002), 56-6-703 (2015), 56-61-101 (2011), and 56-61-102 (2011). In fact, the utilization review statutes have adopted many definitions from the external review statutes, ensuring greater symmetry between the two review structures. § 56-6-703; 2014 Pub. Acts, c. 731. Applicability of the utilization review and external review appeal procedures is dependent upon who is involved in a contemplated appeal. Simply put, the utilization review requirements contemplate the procedures and responsibilities of utilization review agents with respect to appeals from enrollees or healthcare providers' appeals. The external review requirements contemplate the obligations a health carrier must satisfy when an appeal is made to that carrier.

Utilization review is the system by which the necessity and appropriateness of the allocation of healthcare resources are conferred to individuals in Tennessee on a prospective and concurrent basis. § 56-6-703(10)(A). The utilization review statutes seek to ensure that utilization review

agents[1] "adhere to reasonable standards [in] conducting utilization review[s]" and that these agents "coordinat[e] and cooperat[e] [with] health care providers[.]" § 56-6-702. The requirements set forth in Tenn. Code Ann. § 56-6-705 provide the minimum standards with which utilization review agents must comply in order to be in good standing and compliant with Tennessee Insurance Law. Specifically at issue here, is the forty-eight (48) hour appeal timeframe contemplated in Tenn. Code Ann. § 56-6-705(a)(4)(C). This sub-section contemplates an appeal made by a physician or enrollee following a utilization review agent determination not to authorize a service or procedure, which must be adjudicated by a utilization review agent on an expedited basis. This time frame directs utilization review agents to complete such an adjudication of an expedited appeal within forty-eight (48) hours. Accordingly, this section and its time constraints apply to appeals brought to and to be heard by utilization review agents.

Similarly, external review is designed to "provide standards for the establishment and maintenance of procedures by health carriers[2] to assure that covered persons and healthcare providers have the opportunity for the appropriate resolution of grievances[.]" § 56-61-101(b). While the review is similar, the external review statutes seek to ensure that health carriers respond to appeals by covered persons and providers, not utilization review agents. The review requirements in Tenn. Code Ann. § 56-61-109 encompass the procedures by which health carriers must provide expedited review of appealed negative healthcare service or procedure determinations. As such, the seventy-two (72) hour response time frame contemplated in Tenn. Code Ann. § 56-61-109(f)(1) is the time frame by which the health carrier must respond to an appeal.

Despite the many similarities between utilization review and external review, these review processes are not the same. Utilization review contemplates appeals from enrollees and providers directed to utilization review agents; whereas external review contemplates appeals from covered persons and providers to the health carrier. Applicability of the sections depends on the parties involved in the appeal, specifically, to which entity the appeal is addressed.

Please note that the Division has not made an independent investigation of the facts to determine the accuracy or completeness of the information supplied, but has instead relied solely upon the information you have provided. If such information is incorrect or changes substantially, it would be necessary for the Division to reconsider the matter and the position stated herein would be void. This letter expresses the Division's position on enforcement action only and does not purport to express legal conclusions on the issues presented. This position is furnished solely for

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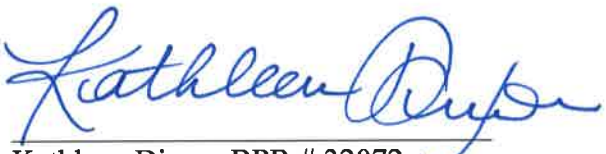
[1] A utilization review agent is "any person or entity, including the state, performing utilization review[.]" Tenn. Code Ann. § 56-6-703(11).

[2] A health carrier is "an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any entity providing a plan of health insurance, health benefits or healthcare services[.]" Tenn. Code Ann. § 56-61-102(17).

the benefit and use of the entities described herein. Please be advised that further publication or use of this position may only be made with the Division's prior written consent.

This response by the Division is to a specific fact situation relating to the utilization review and external review sections and should not be construed as a legal position or opinion of the Commissioner of the Tennessee Department of Commerce and Insurance or of any other official in the Department. Please note that the conclusions contained herein are based upon the representations that have been made to the Division, and any different facts or conditions might require a different response. As each inquiry is reviewed on the specific facts presented, this response is based only on such facts and may not be used as precedent by any person or entity. Any variation in the facts presented to the Division by Mr. Scott White could result in a different conclusion than asserted herein.

If you have further questions or concerns regarding this letter, please feel free to contact me.



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