DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE DIVISION

DIVISION 53
HEALTH BENEFIT PLANS

Mandated Benefit for
Chemical Dependency and Mental or Nervous Conditions (ORS 743.556)

836-053-1404
Definitions; noncontracting providers; co-morbidity disorders

(1) As used in ORS 743.556, this rule and OAR 836-053-1405:

(a) "Mental or nervous conditions" means:

(A) All disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for:

(i) Diagnostic codes 317, 318.0, 318.1, 318.2, 319; Mental Retardation;

(ii) Diagnostic codes 315.00, 315.1, 315.2, 315.9; Learning Disorders;

(iii) Diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9; Paraphilias;

(iv) Diagnostic codes 302.85, 302.6, 302.9; Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and

(v) Diagnostic codes V15.81 through V71.09; "V" codes. This exception does not extend to children 5 years of age or younger for diagnostic codes V61.20; Parent-Child Relational Problem through V61.21; Neglect, Physical Abuse, or Sexual Abuse of Child, and V62.82; Bereavement.

(b) "Chemical dependency" means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems.

(c) "Chemical dependency" does not mean an addiction to, or dependency on:

(A) Tobacco;

(B) Tobacco products; or

(C) Foods.

(2) A non-contracting provider must cooperate with a group health insurer's requirements for review of treatment in ORS 743.556(10)and (11) to the same extent as a contracting provider in order to be eligible for reimbursement.

(3) The exception of a disorder in the definition of "mental or nervous conditions" or "chemical dependency" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

Stat. Auth.: ORS 731.244 and 743.556
Stats. Implemented: ORS 743.556

836-053-1405
General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency

(1) A group health insurance policy issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment of mental or nervous conditions and

chemical dependency, including alcoholism, at the same level as, and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

(2) For the purposes of ORS 743.556, the following standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions is provided at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions:

(a) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for medical and surgical services otherwise provided under the health insurance policy.

(b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services for mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services otherwise provided under the health insurance policy.

(c) Annual or lifetime limits for treatment of mental or nervous conditions and chemical dependency, including alcoholism, may be no less than the annual or lifetime limits for medical and surgical services otherwise provided under the health insurance policy.

(d) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles expenses for prescription drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for other medical services provided under the health insurance policy.

(e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, must be by the same process as drug selection for formulary status applied for drugs intended to treat other medical conditions, regardless of whether such drugs are intended to treat mental or nervous conditions, chemical dependency, including alcoholism, or other medical conditions.

(3) A group health insurance policy issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency, including alcoholism..

(4) A group health insurer that issues or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

(5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical dependency, including alcoholism, may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses arising from other medical condition. Common methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case

management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.

(6) Coverage of mental or nervous conditions and chemical dependency, including alcoholism, may be limited for in-home services.

(7) Nothing in this rule prevents a group health insurance policy from providing coverage for conditions or disorder excepted under the definition of “mental or nervous condition” in OAR 836-053-1400.

(8) The Director shall review OAR 836-053-1400 and this rule and any other materials within two years of the rules’ effective date to determine whether the requirements set forth in the rules are uniformly applied to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

Stat. Auth.: ORS 731.244 and 743.556

Stats. Implemented: ORS 743.556

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE DIVISION

DIVISION 53
HEALTH BENEFIT PLANS

Independent Review

836-053-1325
Procedures for Conducting Independent Reviews

(1) An independent review organization is subject to the following decision-making standards and procedures:

(a) The independent review process is intended to be neutral and independent of influence by any affected party or by state government. The Director may conduct investigations as authorized by law but has no involvement in the disposition of specific cases.

(b) Independent review is a document review process. An enrollee, a health plan or an attending provider may not participate in or attend an independent review in person or obtain reconsideration of a determination by an independent review organization.

(c) An independent review organization shall present cases to medical reviewers in a way that maximizes the likelihood of a clear, unambiguous determination. This may involve stating or restating the questions for review in a clear and precise manner that encourages yes or no answers.

(d) An independent review organization may uphold an adverse determination if the patient or any provider refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond. An independent review organization may overturn an adverse determination if the insurer refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond.

(e) An independent review organization must maintain written policies and procedures covering all aspects of review.

(2) Once the Director refers a dispute, the independent review organization must proceed to final determination unless requested otherwise by both the insurer and the enrollee.

(3) An independent review organization is subject to the following standards with respect to information to be considered for reviews:

(a) An independent review organization must request as necessary and must accept and consider the following information as relevant to a case referred:

(A) [*Information*] **Medical records and other materials** that the insurer is required to submit to the independent review organization under ORS 743.857(3), including information identified in that section that is initially missing or incomplete as submitted by the insurer.

(B) For cases in which the insurer's decision addressed whether a course or plan of treatment was medically necessary:

(i) A copy of the definition of medical necessity from the relevant health insurance policy;

(ii) An explanation of how the insurer's decision conformed to the definition of medical necessity; and

(iii) An explanation of how the insurer's decision conformed to the requirement that the definition of medical necessity be uniformly applied. definition of medical necessity be uniformly applied.

(C) For cases in which the insurer's decision addressed whether a course or plan of treatment was experimental or investigational:

(i) A copy of the definition of experimental or investigational from the relevant health insurance policy;

(ii) An explanation of how the insurer's decision conformed to that definition of experimental or investigational; and

(iii) An explanation of how the insurer's decision conformed to the requirement that the definition of experimental or investigational be uniformly applied.

[*(B)*] **(D)** Other medical, scientific and cost-effectiveness evidence, as described in **subsection (4) of this section**, that is relevant to the case.

(b) After referral of a case, an independent review organization must accept additional information from the enrollee, the insurer or a provider acting on behalf of the enrollee or at the enrollee's request, but only if the information is submitted within seven days of the referral or, in the case of an expedited referral, within 24 hours. The additional information must be related to the case and relevant to statutory criteria.

(c) An independent review organization must ensure the confidentiality of medical records and other personal health information received for use in reviews, in accordance with applicable federal and state laws.

(4) If a course or plan of treatment is determined to be subject to independent review, a determination of whether the adverse decision of an insurer should be upheld or not must be based upon expert clinical judgment, after consideration of relevant medical, scientific and cost-effectiveness evidence and medical standards of practice in the United States. As used in this section:

(a) "Medical, scientific, and cost-effectiveness evidence" means published evidence on results of clinical practice of any health profession that complies with one or more of the following requirements:

(A) 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;

(B) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

(D) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

(E) Findings, studies or research conducted by or under the auspices of a federal government agency or a nationally recognized federal research institute, including the Federal Agency for Healthcare Research and Quality, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Center for Medicaid and Medicare Services,

Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services;

(F) Clinical practice guidelines that meet Institute of Medicine criteria; or

(G) In conjunction with other evidence, peer-reviewed abstracts accepted for presentation at major scientific or clinical meetings.

(b) Medical standards of practice include the standards appropriately applied to physicians or other providers or health care professionals, as pertinent to the case.

(5) The following standards govern the assignment by an independent review organization of appropriate medical reviewers to a case:

(a) A medical reviewer assigned to a case must comply with the conflict of interest provisions in OAR 836-053-1320.

(b) An independent review organization shall assign one or more medical reviewers to each case as necessary to meet the requirements of this subsection. The medical reviewer assigned to a case, or the medical reviewers assigned to a case together, must meet each of the following requirements:

(A) Have expertise to address each of the issues that are the source of the dispute.

(B) Be a clinical peer. For purposes of this paragraph, a clinical peer is a physician or other medical reviewer who is in the same or similar specialty that typically manages the medical condition, procedures or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category, as the attending provider. In a profession that has organized, board-certified specialties, a clinical peer generally will be in the same formal specialty.

(C) Have the ability to evaluate alternatives to the proposed treatment.

(c) Each independent review organization must have a policy specifying the methodology for determining the number and qualifications of medical reviewers to be assigned to each case. The number of reviewers shall be governed by what it takes to meet the following requirements:

(A) The number of reviewers must reflect the complexity of the case and the goal of avoiding unnecessary cost.

(B) The independent review organization may consider, but shall not be bound by, recommendations regarding complexity from the insurer or attending provider.

(C) The independent review organization shall consider situations such as review of experimental and investigational treatments that may benefit from an expanded panel.

(6) An independent review organization shall notify the enrollee and the insurer of its determination of the enrollee's case and provide documentation and reasons for the determination, including the clinical basis for the determination unless the decision is wholly based on application of coverage provisions. In addition:

(a) Documentation of the basis for the determination shall include references to supporting evidence, and if applicable, the reasons for any interpretation regarding the application of health benefit plan coverage provisions, but shall avoid recommending a course of treatment or otherwise engaging in the practice of medicine.

(b) If the determination overrides the health benefit plan's standards governing the coverage issues that are subject to independent review, the reasons shall document why the health benefit plan's standards are unreasonable or inconsistent with sound, evidence-based medical practice.

(c) The written report shall include the qualifications of each medical reviewer but shall not disclose the identity of the reviewer.

(d) Notification of the determination shall be provided initially by phone, e-mail or fax, followed by a written report by mail. In the case of expedited reviews, the initial notification shall be immediate and by phone, followed by a written report.

(7) Except as provided in this section, an independent review organization shall not disclose the identity of a medical reviewer unless otherwise required by state or federal law. The Director shall not require reviewers' identities as part of the contracting process but may examine identified information about reviewers as part of enforcement activities. The identity of the medical director of an independent review organization shall be disclosed upon request of any person.

(8) An independent review organization shall promptly report any attempt at interference by any party, including a state agency, to the Director.

(9) An independent review organization must maintain business hours, methods of contact (including telephone contact), procedures for after-hours requests and other relevant procedures to ensure timely availability to conduct expedited as well as regular reviews.

Stat. Auth.: ORS 731.244, ORS 743.858

Stats. Implemented: ORS 743.858

836-053-1330

Criteria and Considerations for Independent Review Determinations

(1) The following criteria and considerations apply to determinations by an independent review organization:

(a) An independent review organization must use fair procedures in making a determination, and the determination must be consistent with the standards in ORS 743.862 and OAR 836-053-1300 to 836-053-1365.

(b) An independent review organization may override the standards of a health benefit plan governing the coverage issues that are subject to independent review pursuant to ORS 743.857(1) only if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(2) A determination by an IRO of a dispute relating to an adverse decision by an insurer is subject to enforcement under ORS 743.857 to 743.864 if:

(a) The dispute relates to an adverse decision on one or more of the following:

(A) Whether a course or plan of treatment is medically necessary;

(B) Whether a course or plan of treatment is experimental or investigational; or

(C) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854; and

(b) The decision by the independent review organization is made in accordance with the coverage described in the health benefit plan, including limitations and exclusions expressed in the plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment, if the independent review organization determines that**:**

(A) The standards of the insurer are unreasonable or are inconsistent with sound medical practice[.]**; or**

(B) For cases in which the insurer's decision addressed whether a course or plan of treatment was medically necessary:

(i) The insurer's decision did not conformed to the insurer's definition medically necessary in the relevant health insurance policy, or

(ii) The insurer's decision did not conform to the requirement that the definition of medical necessity be uniformly applied; or

(C) For cases in which the insurer's decision addressed whether a course or plan of treatment was experimental or investigational:

(i) The insurer's decision did not conformed to the insurer's definition of experimental or investigational in the relevant health insurance policy, or

(ii) The insurer's decision did not conform to the requirement that the definition of experimental or investigational be uniformly applied.

(3) No provision of OAR 836-053-013 to 836-053-1365 establishes a standard of medical care or creates or eliminates any cause of action.

Stat. Auth.: ORS 731.244, ORS 743.858

Stats. Implemented: ORS 743.858

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE DIVISION

DIVISION 52
INSURANCE POLICIES

NOTE: OAR 836-052-0220 to 836-052-0245 are proposed to be REPEALED

836-052-0220 [To be Repealed]
Statutory Authority; Purpose; Effective Date

(1) OAR 836-052-0220 to 836-052-0245 are adopted pursuant to the general rulemaking authority of the Director of the Department of Insurance and Finance in ORS 731.244 and the specific authority of the Director in ORS 743.556 to adopt rules that carry out requirements in ORS 743.556 relating to coverage under group health insurance policies and contracts for treatment for chemical dependency including alcoholism and for mental or nervous conditions.

(2) OAR 836-052-0220 to 836-052-0245 become effective on July 1, 1988, and apply to group health insurance policies and contracts entered into, renewed or extended on or after July 1, 1988.

Stat. Auth.: ORS 731 & ORS 743
Stats. Implemented: ORS 743.556

836-052-0225 [To be Repealed]
Durational Limits for Health Maintenance Organizations

(1) As provided in this rule, a health maintenance organization may establish and implement durational limits for the categories of treatment specified in ORS 743.556. The durational limit for each category of treatment must be actuarially equivalent to the benefits required by ORS 743.556.

(2) Before issuing or renewing a policy containing durational limits under this rule, a health maintenance organization shall submit to the Director for review and approval the policy form supported by a description of each durational limit that includes the following:

(a) The specific category of treatment;

(b) The durational limit for the category of treatment;

(c) A description of the services to be provided in the treatment;

(d) Any limitations in the length or frequency of the services to be provided;

(e) A demonstration that the services to be provided within the durational limit established by the health maintenance organization for a category of treatment are actuarially equivalent to the services provided with the minimum benefit established in ORS 743.556 for that category of treatment, as shown by the health maintenance organization under section (3) of this rule.

(3) In order to demonstrated the durational limit under section (2) of this rule for a category of treatment specified in ORS 743.556, a health maintenance organization shall describe the quantity of the services that may be purchased in the private health care market for the amount of money stated in ORS 743.556 as the minimum benefit for the category of treatment. The description may use a statistically credible sampling and projection method, or any other method, that is satisfactory to the Director. The method may include averaging to

accommodate variations in cost related to the seriousness of a patient's condition and the intensity of care. The description shall be made separately for each category of treatment, such as inpatient care of mental or nervous conditions for adults, in patient care of mental or nervous conditions for children and adolescents, inpatient care of chemical dependency for adults or inpatient care of chemical dependency for children and adolescents, for which the health maintenance organization establishes a durational limit. For each category of treatment, the health maintenance organization also shall include an estimate of the costs to the health maintenance organization for providing the services within the category of treatment.

(4) The Director may disapprove a durational limit submitted under this rule as not being actuarially equivalent to benefits required by ORS 743.556 if the Director determines either of the following:

(a) That the services to be provided within the durational limit for a category of treatment are not equivalent in quality or treatment setting to the services provided within the corresponding minimum benefit established in ORS 743.556. In order to determine whether services in a category of treatment are equivalent in quality or treatment setting, the Director may consult with appropriate state health agencies, such as the Health Division;

(b) That the durational limit is unsubstantiated.

Stat. Auth.: ORS 731.244 & ORS 743.556

Stats. Implemented: ORS 743.556

836-052-0230 [To be Repealed]

Provider Services Limits for Insurers and Health Care Contractors

(1) Before an insurer or a health care service contractor other than a health maintenance organization issues or renews a policy with respect to which the insurer or health care service contractor contracts with one or more providers to furnish services for chemical dependency or mental or nervous conditions under the policy, the insurer or health care service contractor shall submit the policy form or contract, supported by the following, to the Director for review and approval:

(a) A description of the contracted services, including the treatment settings for the services, and a demonstration of their equivalency to the services required under ORS 743.556;

(b) A statement of the policy limits established for the contracted services;

(c) A statement of the discount for each service furnished by the provider.

(2) When an insurer or a health care service contractor other than a health maintenance organization contracts with one or more providers of health care services to furnish services under a group policy form or contract, the insurer or health care contractor must demonstrate to the Director, for the Director's review and approval, that the policy form or contract offers services that equal or exceed the range of services and treatment settings provided within the benefit levels specified in ORS 743.556. The insurer or health care services contractor must demonstrate that the discount provided in the contract for services furnished by the provider and the limited established for contracted services allow for services that equal or exceed the range of services and treatment settings provided within the benefit levels specified in ORS 743.556.

(3) If the Director has previously reviewed and approved a policy form or contract under this rule, the Director need not review a renewal of the policy unless the contract with the provider is altered with regard to services or policy limits.

Stat. Auth.: ORS 731.244 & ORS 743.556

Stats. Implemented: ORS 743.556

836-052-0235 [To be Repealed]
Copayment, Health Maintenance Organizations

For the purpose of ORS 743.556(23)(a), a health maintenance organization may not establish a provision for enrollee cost-sharing that provides that the amount to be paid by the enrollee reduces the amount of the minimum benefits required to be provided by the health maintenance organization under ORS 743.556.

Stat. Auth.: ORS 731 & ORS 743
Stats. Implemented: ORS 743.556

836-052-0240 [To be Repealed]
Renewal of Benefits

A group health insurance policy or contract that is subject to ORS 743.556 shall state whether the benefits described in ORS 743.556 renew in full on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

Stat. Auth.: ORS 731 & ORS 743
Stats. Implemented: ORS 743.556

836-052-0245 [To be Repealed]
Prior Approval

(1) Except as provided for health maintenance organizations in section (2) of this rule, when an insurer or a health care service contractor requires prior approval of treatment as part of the utilization review process under ORS 743.556, the insurer or health care services contractor may limit payments on claims under an urgent or emergency admission only as provided in this section. An insurer or health care service contractor that limits such claims must provide in the policy that each claim under the urgent or emergency admission is limited to not fewer than 48 hours after the admission or any additional period during which the insured is unable to notify the insurer or health care service contractor of the claim either because of incapacity of the insured or because the insurer cannot be reached.

(2) A health maintenance organization is not required under section (1) of this rule to provide coverage for the 48-hour period or any additional period prior to notice by the patient if provision of such coverage is contrary to any limitation imposed by the health maintenance organization under ORS 743.556(23)(c) on the receipt of covered services.

Stat. Auth.: ORS 731 & ORS 743
Stats. Implemented: ORS 743.556