72A.327 HEALTH CLAIMS; RIGHTS OF APPEAL.

(a) An insured whose claim for medical benefits under chapter 65B is denied because the treatment or services for which the claim is made is claimed to be experimental, investigative, not medically necessary, or otherwise not generally accepted by licensed health care providers and for which the insured has financial responsibility in excess of applicable co-payments and deductibles may appeal the denial to the commissioner.

(b) This section does not apply to claims for health benefits which have been arbitrated under section 65B.525, subdivision 1.

(c) A three-member panel shall review the denial of the claim and report to the commissioner. The commissioner shall establish a list of qualified individuals who are eligible to serve on the panel. In establishing the list, the commissioner shall consult with representatives of the contributing members as defined in section 65B.01, subdivision 2, and professional societies. Each panel must include: one person with medical expertise as identified by the contributing members; one person with medical expertise as identified by the professional societies; and one public member. The commissioner, upon initiation of an arbitration, shall select from each list three potential arbitrators and shall notify the issuer and the claimant of the selection. Each party shall strike one of the potential arbitrators and an arbitrator shall be selected by the commissioner from the remaining names of potential arbitrators if more than one potential arbitrator is left. In the event of multiparty arbitration, the commissioner may increase the number of potential arbitrators and divide the strikes so as to afford an equal number of strikes to each adverse interest. If the selected arbitrator is unable or unwilling to serve for any reason, the commissioner may appoint an arbitrator, which will be subject to challenge only for cause. The party that denied the coverage has the burden of proving that the services or treatment are experimental, investigative, not medically necessary, or not generally accepted by licensed health care professionals. In determining whether the burden has been met, the panel may consider expert testimony, medical literature, and any other relevant sources. If the party fails to sustain its burden, the commissioner may order the immediate payment of the claim. All proceedings of the panel and any documents received or developed by the review process are nonpublic.

(d) A person aggrieved by an order under this section may appeal the order. The appeal shall be pursuant to section 65B.525 where appropriate, or to the district court for a trial de novo, in all other cases. In nonemergency situations, if the insurer has an internal grievance or appeal process, the insured must exhaust that process before the external appeal. In no event shall the internal grievance process exceed the time limits described in section 72A.201, subdivision 4a.

(e) If prior authorization is required before services or treatment can be rendered, an appeal of the denial of prior authorization may be made as provided in this section.

(f) The commissioner shall adopt procedural rules for the conduct of appeals.

(g) The permanent rulemaking authority granted in this section is effective June 2, 1989, regardless of the actual effective date of January 1, 1990.

History: *1989 c 330 s 34*