ARIZONA
DEPARTMENT OF INSURANCE
& FINANCIAL INSTITUTIONS

Pharmacy Benefit Managers

Licensing Regulations

Relevant Statutes

Table of Contents

Title 10. Corporations and Associations

Chapter 1. General Provisions

Article 2. Filing Documents and Fees

10-128. Certificate of good standing

A. A person may apply to the commission to furnish a certificate of good standing for a domestic or foreign corporation.

B. A certificate of good standing sets forth all of the following:

1. The domestic corporation's corporate name or the foreign corporation's corporate name used in this state.

2. That either:

(a) The domestic corporation is incorporated under the laws of this state and the date of its incorporation.

(b) The foreign corporation is authorized to transact business in this state.

3. That all affidavits and annual reports required before the date of the certificate have been filed with the commission.

4. That all annual filing fees due before the date of the certificate have been paid.

5. That, according to the records of the commission, the corporation is in good standing in this state.

C. Subject to any qualification stated in the certificate, a certificate of good standing issued by the commission may be relied on as conclusive evidence of the matters stated in the certificate.

Title 20. Insurance

Chapter 1. General Provisions

Article 1. Scope of Title

20-102. Definition of director

In this title, title 6, title 32, chapters 9 and 36, title 41, chapter 31 and title 44, chapter 2.1, unless the context otherwise requires:

1. "Director" or "administrator" means the director of the department of insurance and financial institutions.

2. When used with reference to a member of the governing body of an insurer, director includes trustee.

20-105. "Person" defined

"Person" includes an individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation and entity.

Chapter 2. Transaction of Insurance Business

Article 9. Insurance Administrators

20-485. Definitions; scope

A. In this article, unless the context otherwise requires:

1. "Administrator" means any person who collects charges or premiums from or paid on behalf of, or who adjusts or settles claims by, residents of this state in connection with life or health insurance coverage or annuities other than any of the following:

(a) An employer on behalf of the employer's employees or the employees of one or more subsidiary or affiliated corporations of the employer.

(b) A union on behalf of its members.

(c) An insurer authorized to transact insurance in this state, including its employees and sales representatives, to the extent that it collects charges or premiums from or paid on behalf of, or adjusts or settles claims by, residents of this state in connection with life or health insurance coverage or annuities lawfully issued and delivered or assumed in this state and pursuant to the laws of this state or another state and for which the insurer or an affiliated insurer is presently directly liable.

(d) An insurer authorized to transact insurance in this state, including its employees and sales representatives, to the extent that it collects charges or premiums from or paid on behalf of, or adjusts or settles claims by, residents of this state in connection with life or health insurance coverage or annuities lawfully issued and delivered or assumed in this state and pursuant to the laws of this state or another state and for which an unaffiliated insurer is presently directly liable.

(e) A person other than an insurer, to the extent that the person's activities are limited to the collection of charges or premiums from or paid on behalf of, or the adjustment or settlement of claims by, residents of this state in connection with life and health insurance coverage issued and delivered or assumed by an affiliated insurer authorized to transact insurance in this state and for which the affiliated insurer is presently directly liable.

(f) A life or disability insurance producer who is licensed in this state or an employee of a licensed producer working at the direction and under the supervision of a licensed producer if the producer or the producer's employee does not adjust or settle claims.

(g) A creditor on behalf of the creditor's debtors with respect to insurance covering a debt between the creditor and its debtors.

(h) A trust and its trustees, agents and employees acting pursuant to the trust established in conformity with 29 United States Code section 186.

(i) A trust exempt from taxation under section 501(a) of the internal revenue code and its trustees and employees acting pursuant to the trust, or a custodian and its agents and employees acting pursuant to a custodian account that meets the requirements of section 401(f) of the internal revenue code.

(j) A financial institution or money transmitter that is subject to supervision or examination by federal or state banking authorities if the financial institution or money transmitter does not adjust or settle claims.

(k) A credit card issuing company that advances for and collects premiums or charges from its credit card holders who have authorized such collection, if the company does not adjust or settle claims.

(l) A person who adjusts or settles claims in the normal course of the person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

(m) An adjuster who is licensed in this state while acting in accordance with an adjuster's license.

(n) A person who acts only as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(o) A credit card processing company that processes payments or charges for premiums if the company does not adjust or settle claims.

(p) A qualified marketplace platform on behalf of qualified marketplace contractors that have executed a written contract with the qualified marketplace platform that complies with the requirements of section 23-1603, subsection A.

(q) An employee of the group policyholder who collects or remits premiums for group life insurance, group annuities or group or blanket disability insurance if the person does not adjust claims or receive any commissions.

(r) An administrator of a trust that was established to provide life insurance, disability insurance or annuities to participants in the trust and that is also a group policyholder. The administrator may act only as an administrator of the trust and may not adjust or settle claims.

2. "Affiliate" or "affiliated" means a person who directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with a specified person.

3. "Charges" means cost sharing requirements, including applicable coinsurance, copayments, deductibles or other amounts payable by an insured under the terms of an insurance contract.

4. "Control" means the direct or ultimate possession of the power to direct or cause the direction of the management and policies of a person whether through voting rights, contracts, other than commercial contracts for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office. Control exists if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent or more of the voting rights of any other person, including the right to elect or appoint the officers or directors of a nonprofit corporation.

5. "Insurer" means any person who provides life or health insurance coverage in this state or who transacts annuity business in this state. Insurer includes an authorized insurer, hospital, medical, dental or optometric service corporation or health care services organization or any other person providing a plan of insurance subject to the laws of insurance of this state. Insurer does not include a self-insured or a self-funded employee benefit plan if regulation of that plan is preempted pursuant to section 1144(a) of the employee retirement income security act of 1974 (29 United States Code section 1144(a)) but does include an insurer who provides coverage as part of an employee benefit plan.

6. "Principal" means a person who has the authority to enter into written agreements on behalf of the administrator pursuant to section 20-485.01.

7. "Qualified marketplace contractor":

(a) Means any person or organization, including an individual, corporation, limited liability company, partnership, sole proprietor or other entity, that enters into an agreement with a qualified marketplace platform to use the qualified marketplace platform's digital platform to provide services to third-party individuals or entities seeking those services.

(b) Does not include a contractor if the services performed consist of transporting freight, sealed and closed envelopes, boxes or parcels or other sealed and closed containers for compensation.

8. "Qualified marketplace platform":

(a) Means an organization, including a corporation, limited liability company, partnership, sole proprietor or other entity, that both:

(i) Operates a digital website or digital smartphone application that facilitates the provision of services by qualified marketplace contractors to individuals or entities seeking those services.

(ii) Accepts service requests from the public only through its digital website or digital smartphone application and does not accept service requests by telephone, by fax or in person at physical retail locations.

(b) Does not include any digital website or smartphone application if the services facilitated consist of transporting freight, sealed and closed envelopes, boxes or parcels or other sealed and closed containers for compensation.

B. To the extent that an insurer is subject to subsection A, paragraph 1, subdivision (d) of this section, it shall comply with this article except sections 20-485.10 and 20-485.12.

C. This article does not apply to a person acting exclusively as a third party intermediary entity as prescribed in section 20-120.

20-485.01. Written agreement; provisions; maintenance of records

A. No person may act as an administrator and no administrator may collect a premium without a written agreement between the person as administrator and the insurer for whom the services are rendered. Such written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and for five years thereafter.

B. The written agreement shall contain provisions which include the requirements of sections 20-485.03 through 20-485.10 except as those requirements do not apply to the functions performed by the administrator. The agreement shall include a provision that the insurer shall provide thirty days' written notice to the administrator of termination or cancellation of the agreement. The agreement shall also include a provision that the insurer shall provide fifteen days' written notice to the director of termination or cancellation or any other change in the agreement.

C. If a policy is issued to a trustee or trustees, a copy of the trust agreement and any amendments to such agreement shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and for five years thereafter.

20-485.02. Administrator as intermediary between insurer and insured; right of action preserved

If an insurer utilizes the services of an administrator under the terms of a written agreement as required in section 20-485.01, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer, and the payment of return premiums or claims by the insurer to the administrator shall not be deemed payment to the insured or claimant until such payments are received by the insured or claimant. Nothing in this article shall limit any right of the insurer against the administrator resulting from such administrator's failure to make payments to the insurer, insureds or claimants.

A. Every administrator shall maintain at the administrator's principal administrative office for the duration of the written agreement required by section 20-485.01 and for five years thereafter adequate books and records of all transactions among the administrator, insurers and insured persons. The books and records shall be maintained in accordance with prudent standards of insurance record keeping.

B. The director shall have access to books and records maintained by the administrator for the purpose of examination, audit and inspection. Any trade secrets contained in the books and records, including the identity and addresses of policyholders and certificate holders, shall be

confidential, except the director may use the information in any proceedings instituted against the administrator.

C. The director may:

1. Share nonpublic documents, materials or other information with other state, federal and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries and with state, federal and international law enforcement authorities if the recipient agrees and warrants that it has the authority to maintain the confidentiality and privileged status of the documents, materials or other information.

2. Receive documents, materials and other information from the national association of insurance commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other jurisdictions and shall maintain as confidential or privileged any document, material or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

3. Enter into agreements that govern the sharing and use of documents, materials and other information and that are consistent with this section.

D. A disclosure to or by the director pursuant to this section or as a result of sharing information pursuant to subsection C of this section is not a waiver of any applicable privilege or claim of confidentiality in the documents, materials or other information disclosed or shared.

E. The insurer retains the right of continuing access to books and records maintained by the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in such books and records.

F. The director may require an administrator to provide, on a quarterly basis in a form acceptable to the director, additional information that is necessary for the protection of the public.

G. The director may examine the business practices, books and records of any administrator as often as the director deems appropriate. The administrator shall pay the cost of only one examination each year.

20-485.04. Advertising; approval

An administrator may use only such advertising pertaining to the business underwritten by an insurer as has been approved by such insurer in advance of its use.

20-485.05. Inclusion of underwriting standards

The agreement required in section 20-485.01 shall make provision with respect to the underwriting or other standards pertaining to the business underwritten by such insurer.

20-485.06. Charges or premiums collected held in fiduciary capacity; establishment of account; disbursements

A. All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled to such funds or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator.

B. If charges or premiums deposited in a fiduciary account have been collected on behalf of or for more than one insurer, the administrator shall keep records clearly recording the deposits in and withdrawals from such account on behalf of or for each insurer. The administrator shall, upon request of an insurer, furnish such insurer with copies of such records pertaining to deposits and withdrawals on behalf of or for such insurer.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account. Withdrawals from such account shall be made, as provided in the written agreement between the administrator and the insurer required by section 20-485.01, for any of the following:

1. Remittance to an insurer entitled to such remittance.

2. Deposit in an account maintained in the name of such insurer.

3. Transfer to and deposit in a claims-paying account, with claims to be paid as provided by section 20-485.07.

4. Payment to a group policyholder for remittance to the insurer entitled to such remittance.

5. Payment to the administrator of such administrator's commission, fees or charges.

6. Remittance of return premiums to the person or persons entitled to such return premiums.

20-485.07. Payment of claims on behalf of insurer

All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on drafts of and as authorized by such insurer.

20-485.08. Delivery of written communications

Any policies, certificates, booklets, termination notices or other written communications delivered by the insurer to the administrator for delivery to its policyholders shall be delivered by the administrator promptly after receipt of instructions from the insurer to do so.

20-485.09. Adjustment or settlement of claims or charges; compensation

A. Compensation to an administrator for any policies where such administrator adjusts or settles claims shall not be contingent on claim experience. This subsection does not prevent the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

B. An administrator may collect charges in accordance with the written agreement between the administrator and the insurer. The written agreement must prescribe the applicable standards for the permissible collection of charges by the administrator. Unless the administrator is licensed as a collection agency pursuant to title 32, chapter 9, the administrator may not collect charges that have remained unpaid on an account that has been inactive for more than twelve months.

20-485.10. Deposit or surety bond of administrators; amount; purpose

Every administrator shall possess and maintain a deposit in favor of this state to be held in trust for the benefit and protection of insureds and insurers whose monies the administrator handles consisting of cash, securities eligible for investment pursuant to chapter 3, articles 1 and 2 of this title, or a surety bond in a form acceptable to the director and issued by a corporate surety authorized to transact business in this state. The amount of the deposit shall be ten per cent of the amount of total funds handled unless the director determines that a lesser amount is adequate for the protection of the public but in no case shall the bond be less than five thousand dollars. The amount of the deposit shall be determined by the total funds handled by the administrator during the preceding year, or if no funds were handled during the preceding year, the amount of funds reasonably estimated to be handled during the current calendar year by the administrator. The amount of such deposit is payable on the failure of the administrator to pay benefits it is legally obligated to pay and shall provide protection to the insurers and insureds against loss by reason of acts of fraud or dishonesty and may include individual bonds or schedule or blanket forms of bonds.

20-485.11. Notice to insureds; statement of charge or premium for coverage; conflict of interest prohibited

A. If the services of an administrator are utilized, such administrator shall provide a written notice approved by the insurer to insured individuals advising them of the identity of and relationship among the administrator, the policyholder and the insurer.

B. If an administrator collects monies, the administrator shall identify and state separately in writing to the person paying to the administrator any charge or premium for insurance coverage the amount of any such charge or premium specified by the insurer for such insurance coverage.

C. The administrator or any employee of the administrator shall not directly or through control of any other person have an ownership interest in any insurer except as a shareholder of less than one per cent of the shares of any publicly owned insurer. The administrator or a principal of the administrator may not receive from an insurer, for the placement of insurance administered by the administrator, a commission whether in monetary or nonmonetary form directly dependent upon the amount of such insurance.

D. Subject to subsection C of this section, before entering into a written agreement pursuant to section 20-485.01 with an unaffiliated insurer, an administrator shall provide written notice to the unaffiliated insurer of the identity of each insurer with which the administrator is affiliated and the nature of the affiliation.

E. If an administrator or an employee of the administrator acts directly or indirectly as an insurance producer with respect to a policy it administers in this state, the administrator shall provide the policyholder and the person insured under that policy with written notice of that relationship.

F. If an administrator or an employee of the administrator acts directly or indirectly as an insurance producer with respect to an insurance policy available in this state that has substantially the same type of coverage as a policy it administers in this state, the administrator shall provide the insurer for which it acts with written notice of the identity of the other insurer and its relationship to it.

20-485.12. Certificate of registration; fees; expiration; revocation; civil penalties; violations; classification; injunctive relief

A. A person may not claim to be an administrator in this state unless the person holds a valid certificate of registration as an administrator issued by the director.

B. An application for a certificate of registration and an application to renew a certificate shall be in the form prescribed by the director and shall be accompanied by the fee prescribed in section 20-167. The fee is not refundable if the application or renewal application is denied. Each application for a certificate shall include the following information and documents:

1. A financial statement that is certified by an officer of the applicant on a form acceptable to the director and that includes current financial information covering the ninety days immediately preceding the date that the application is filed with the director. The financial statement shall include the following:

(a) A disclosure of the total amount of Arizona monies projected to be handled for the next calendar year.

(b) An income statement and a balance sheet prepared in accordance with generally accepted accounting principles for the two years immediately preceding the date that the application is filed. The applicant shall not submit consolidated income statements or balance sheets.

2. All of the administrator's basic organization documents and amendments to these documents, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable document.

3. An organizational chart that identifies each member of the holding company system that directly or indirectly controls the administrator and every affiliate the administrator directly or indirectly controls.

4. The administrator's bylaws, rules or regulations or similar documents that regulate the administrator's internal affairs.

5. Biographical affidavits to be completed by the individuals responsible for the administrator's affairs, including affidavits for all members of the board of directors, the board of trustees, the executive committee or any other governing board or committee, the principal officers of the corporation or the partners or members of the partnership or association, shareholders that directly or indirectly hold at least ten percent of the voting securities of the administrator and any other person who exercises control or influence over the affairs of the administrator. The biographical affidavits shall include information concerning the personal history, business record, insurance experience and other pertinent facts as the director may require, including whether the affiant has been the subject of an investigation by any regulatory authority or has had any license of any type denied, suspended or revoked in any jurisdiction.

6. The administrator's complete name and address for all offices in each jurisdiction.

7. A declaration that states whether the administrator has:

(a) Been previously licensed to transact any kind of insurance in this state or any other jurisdiction and whether that license has been refused, suspended or revoked.

(b) Been indebted to any person, including all of the relevant details.

(c) Had an administrative agreement canceled, including all of the relevant details.

8. The details about the administrator's capacity to collect premiums or administer claims on behalf of the insurer in this state.

9. The written notice, approved by the insurer, that the administrator will provide to insured individuals and that advises the insured individuals of the administrator's identity and the relationship between the administrator and the insurer for each executed insurance administrative agreement filed in this state.

10. An affidavit signed by an officer of the administrator who is authorized by the administrator to verify the facts stated in the application.

C. The director shall issue the certificate of registration unless the director finds that the applicant is not competent or financially responsible, has had an insurance license denied for

cause by any state or has failed to comply with any requirement of this article. The certificate remains in effect until the director suspends or revokes the certificate or until the director accepts the voluntary termination of the certificate. On revocation or termination, the administrator shall immediately deliver the certificate to the director.

D. Unless the certificate of registration is surrendered, suspended or revoked, a certificate of registration issued pursuant to this section to an administrator remains in effect for as long as the administrator continues in business in this state and the administrator remains in compliance with all of the requirements applicable to administrators prescribed by this title.

E. On or before March 1 of each year, each administrator that has an effective certificate of registration shall file a renewal application with the director, on a form approved by the director, that consists of a financial statement of the administrator's current financial condition, transactions and affairs as of December 31 of the preceding calendar year. The annual financial statement shall include a disclosure of the total amount of Arizona monies handled for the preceding year, including the income statement and balance sheet required by subsection B of this section and any additional information that the director may require. At least two officers of the administrator shall verify the annual financial statement. The administrator shall include with the annual financial statement the filing fee prescribed in section 20-167. The director may allow an administrator that has failed to file its annual financial statement or pay its fees on time to file the statement and pay the fees if the administrator pays an additional fee to be determined by the director of not more than $25 for each day of delinquency.

F. The director may request further information from the administrator at any time regarding a previously filed application or the annual financial statement prescribed by subsection E of this section.

G. Within thirty days after the change becomes effective, the administrator shall provide the director with written notice of any change in the application on which the certificate of registration was issued and of any change in the administrator's ownership or control.

H. After notice and a hearing, the director may either suspend or revoke a certificate of registration for any reason for which the issuance of a certificate could be denied or for any of the following reasons:

1. The administrator is in an unsound financial condition or in a condition that renders further administrative services in this state by the administrator hazardous to policyholders, claimants, beneficiaries or any other person.

2. The administrator knowingly failed to comply with any lawful order of the director.

3. The administrator violated any provision or requirement of this title or any rule adopted by the director pursuant to this title.

I. In lieu of or in addition to suspension or revocation, if the director finds grounds pursuant to subsection H of this section to suspend or revoke an administrator's certificate of registration, the

director may impose a civil penalty of at least $1,000 and not more than $10,000. The civil penalty is in addition to any other penalties that may be imposed for violations of this title or other laws of this state.

J. Any civil penalties imposed pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

K. Any person who violates any provision of this article other than subsection A of this section is guilty of a class 3 misdemeanor. A person who violates subsection A of this section is guilty of a class 5 felony.

L. If the director believes from evidence satisfactory to the director that a person is violating or is about to violate subsection A of this section, the director may order the person to cease and desist and, through the attorney general, may file a complaint in the superior court in the county in which the person transacts insurance business to enjoin or restrain the person from continuing or engaging in the violation or doing any act in furtherance of the violation. If the director orders the person to cease and desist, the person may request a hearing pursuant to title 41, chapter 6, article 10. If a complaint is filed in superior court, the court has jurisdiction over the proceedings and may enter an order or judgment awarding appropriate relief.

Chapter 15. Utilization Review

Article 1. General Provisions

20-2501. Definitions; scope

A. In this chapter, unless the context otherwise requires:

1. "Adverse determination":

(a) Means a utilization review determination by the utilization review agent that a requested service or claim for service or a denial, reduction or termination of a service, in whole or in part, is not a covered service, or is not medically necessary or appropriate, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the plan if that determination results in a documented denial or nonpayment of the service or claim.

(b) Includes a rescission.

2. "Benefits based on the health status of the insured" means a contract of insurance to pay a fixed benefit amount, without regard to the specific services received, to a policyholder who meets certain eligibility criteria based on health status including:

(a) A disability income insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is deemed to have a disability as defined by the policy terms.

(b) A hospital indemnity policy that pays a fixed daily benefit during hospital confinement.

(c) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is certified by a licensed health care professional as chronically ill as defined by the policy terms.

(d) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who suffers from a prolonged physical illness, disability or cognitive disorder as defined by the policy terms.

3. "Claim":

(a) Means a request for payment for a service already provided.

(b) Does not include:

(i) Claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers.

(ii) A request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

4. "Covered service" means a service that is included in a policy, evidence of coverage or similar document that specifies which services, insurance or other benefits are included or covered.

5. "Denial":

(a) Means a direct or indirect determination regarding all or part of a request for any service.

(b) Includes a denial, reduction or termination of a service or a rescission or a direct determination regarding a claim that may trigger a request for review.

(c) Does not include:

(i) Enforcement of a health care insurer's deductibles, copayments or coinsurance requirements or adjustments for usual and customary charges, deductibles, copayments or coinsurance requirements for a service or coordination of benefits between health care insurers.

(ii) The rejection of a request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

6. "Final internal adverse determination" means an adverse determination that is upheld, in whole or in part, at the completion of the health care insurer's internal levels of review or an adverse determination with respect to which the internal levels of review have been waived or deemed exhausted.

7. "Grandfathered individual plan" means coverage provided by an individual health care insurer which was purchased before March 23, 2010 and which has not lost such status due to changes in benefits.

8. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, prepaid dental plan organization, medical service corporation, dental service corporation or optometric service corporation or a hospital, medical, dental and optometric service corporation.

9. "Health care setting" means an institution providing health care services, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

10. "Indirect denial" means a failure to communicate authorization or nonauthorization to the member by the utilization review agent within the prescribed time frames pursuant to section 20-3404 after the utilization review agent receives the request for a covered service.

11. "Internal levels of review" means:

(a) An expedited medical review and expedited appeal pursuant to section 20-2534.

(b) An initial internal appeal pursuant to section 20-2535.

(c) A voluntary internal appeal pursuant to section 20-2536, if applicable.

12. "Provider" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for providing care, treatment and services rendered to a patient.

13. "Rescission" means a retroactive cancellation of coverage that is not related to a failure to timely pay required premiums.

14. "Service" means a diagnostic or therapeutic medical or health care service, benefit or treatment.

15. "Utilization review" means a system for reviewing the appropriate and efficient allocation of inpatient hospital resources, inpatient medical services and outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and health care services or claims for services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services. Utilization review does not include elective requests for the clarification of coverage.

16. "Utilization review agent" means a person or entity that performs utilization review. For purposes of article 2 of this chapter, utilization review agent has the same meaning prescribed in section 20-2530. For purposes of this chapter, utilization review agent does not include:

(a) A governmental agency.

(b) An agent that acts on behalf of the governmental agency.

(c) An employee of a utilization review agent.

17. "Utilization review plan" means a summary description of the utilization review guidelines, protocols, procedures and written standards and criteria of a utilization review agent.

B. For the purposes of this chapter, utilization review by an optometric service corporation applies only to nonsurgical medical and health care services.

20-2502. Utilization review activities; exemptions

A. A utilization review agent shall not conduct utilization review in this state unless the utilization review agent meets or is exempt from this article.

B. A person is exempt from sections 20-2504, 20-2505, 20-2506, 20-2507 and 20-2508 and section 20-2509, subsection A if the person:

1. Is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

2. Conducts internal utilization review for hospitals, home health agencies, clinics, private offices or other health facilities or entities if the review does not result in the approval or denial of payment for hospital or medical services.

3. Conducts utilization review activities exclusively for work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Conducts utilization review activities exclusively for a self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974 (29 United States Code section 1144(b)).

C. A utilization review agent shall conduct utilization review in accordance with the agent's utilization review plan that is on file with the department pursuant to section 20-2505 and in accordance with section 20-2532.

20-2503. Utilization review standards; applicability; definition

A. The utilization review standards established in this chapter apply to prospective, concurrent and retrospective utilization review for:

1. Inpatient admissions to hospitals and other inpatient facilities.

2. Outpatient admissions to surgical facilities.

3. Outpatient surgical services provided in a health care provider's office.

4. Medical, surgical and health care services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services.

B. For purposes of this section "inpatient admissions" includes inpatient admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services at a licensed hospital or other inpatient facility.

20-2504. Utilization review agents; certification; rules

A. The director shall issue a certificate to a utilization review agent that meets all of the requirements of this chapter and all applicable rules. A utilization review agent shall submit a signed and notarized application on a form prescribed by the director.

B. A certificate is not transferable.

C. The director may adopt rules consistent with the requirements of this chapter.

D. Except as provided in section 20-2532, information required by the department with respect to customers, patients or utilization review plans is confidential and is not open to public inspection.

E. The utilization review agent shall pay all certification expenses as provided in section 20-2506.

20-2505. Application for certification

A utilization review agent applying for a certificate shall submit the following information to the department:

1. A signed and notarized application on a form prescribed by the director.

2. A utilization review plan that includes a summary description of review guidelines, protocols and procedures, standards and criteria to be used in evaluating inpatient hospital care, inpatient medical care, outpatient surgical care and any medical, surgical and health care services that may be covered by a health care insurer and the provisions by which patients, providers or hospitals may seek reconsideration or appeal of decisions made by the utilization review agent.

3. The professional qualifications of the personnel either employed or under contract to perform the utilization review. Personnel conducting utilization review shall have current licenses that are in good standing and without restrictions from a state health care professional licensing agency in the United States and may be a member of a profession that practices inpatient hospital or outpatient surgical care.

4. A description of the policies and procedures that ensure that a representative of the utilization review agent is available to receive and send the notice and acknowledgments prescribed in article 2 of this chapter and is reasonably accessible to patients and providers in this state and the department by a toll free telephone line or by acceptance of long-distance collect calls for forty hours each week during normal business hours.

5. A description of the policies and procedures that ensure that the utilization review agent will follow applicable state and federal laws to protect the confidentiality of individual medical records.

6. A copy of the materials or a description of the procedure designed to inform patients and providers, as appropriate, of the requirements of the utilization review plan.

20-2506. Certification; responsibilities of department; cost recovery

A. The director shall examine the affairs, transactions, accounts and records of each utilization review agent before issuing an initial certificate and as often as the director deems it necessary in order to determine if a utilization review agent is in compliance with this chapter. The department shall not make any determination of quality of care, appropriateness of utilization review recommendations or medical necessity relating to any plan of care or treatment.

B. All examination and examination related expenses shall be charged to the utilization review agent and shall be paid by the director out of the insurance examiners' revolving fund in accordance with section 20-159.

C. The director may use independent contract examiners pursuant to sections 20-148 and 20-149 to perform the examinations under this section.

D. Any expenses of examinations not paid by the utilization review agent within thirty days of the billing of the examination expenses shall be paid by the health care insurer that used the services or that contracted with the utilization review agent. If more than one health care insurer used the services of or contracted with a utilization review agent each health care insurer shall pay an equal share of the uncollected expenses.

20-2507. Certificates; renewal

A. A certificate expires on the third anniversary of its effective date unless the certificate is renewed for a three year term as provided in this section.

B. A certificate holder may renew an unexpired certificate for an additional three year term if the certificate holder meets the requirements of this chapter.

20-2508. Denial, suspension or revocation of certificates; hearing; civil penalties

A. The director shall deny a certificate if the director finds that the utilization review agent does not:

1. Have an allopathic or osteopathic physician available to supervise utilization review activities of any medical, surgical or health care services except that:

(a) A dental service corporation that is licensed pursuant to chapter 4, article 3 of this title and a prepaid dental plan organization that is licensed pursuant to chapter 4, article 7 of this title may have a licensed dentist supervise or conduct utilization review activities for health care services that involve dental care.

(b) An optometric service corporation that is licensed pursuant to chapter 4, article 3 of this title may have a licensed optometrist supervise or conduct utilization review activities for health care services that involve optometric care.

(c) A utilization review agent shall have a licensed chiropractor supervise or conduct utilization review activities for health care services that are performed by a chiropractor and within the chiropractor's scope of practice pursuant to title 32, chapter 8.

2. Meet all applicable department rules relating to the qualifications of utilization review agents or the performance of utilization review.

3. Provide assurances satisfactory to the director that the procedure and policies of the utilization review agent will protect the confidentiality of medical records and the utilization review agent will be reasonably accessible to patients and providers in this state and the department by a toll free telephone line or by acceptance of long-distance collect calls for forty hours each week during normal business hours.

B. The director shall deny a certificate to a utilization review agent who has been convicted of a misdemeanor involving moral turpitude or a felony or who employs a person who has been convicted of a felony.

C. The director may suspend, revoke or refuse to renew a certificate issued under this chapter if after giving notice to the utilization review agent, and holding a hearing if demanded by the agent, the director finds that the agent has violated this chapter or a rule adopted under this chapter.

D. If after a hearing the director finds that the agent has violated this chapter or an applicable rule or order adopted under this chapter, the director shall issue an order that specifies the violation and may impose a civil penalty of not more than two hundred fifty dollars for each violation or an aggregate civil penalty of not more than two thousand five hundred dollars. The director may also impose a civil penalty of not more than two thousand five hundred dollars for each knowing violation or an aggregate civil penalty of not more than fifteen thousand dollars. The director shall deposit, pursuant to sections 35-146 and 35-147, all monies in the state general fund. A civil penalty is in addition to any other applicable penalty or restraint provided in this chapter and may be recovered in a civil action brought by the director.

E. A certificate does not expire or terminate until a pending department investigation is resolved but is suspended on the date it would otherwise expire or terminate. The utilization review agent shall not transact business in this state until the investigation is completed.

F. When the director suspends or revokes a certificate the director shall immediately notify the utilization review agent either by personal service or by mail addressed to the agent at the agent's address of record. Notice by mail is effective at the time it is mailed.

G. The utilization review agent shall deliver a revoked or suspended certificate to the director on the director's request.

H. The director shall not issue a new certificate earlier than one year after the date of a previous revocation. Agents shall reapply to the director and shall meet all the requirements of this chapter to obtain a new certificate.

I. If the certificate of a firm or corporation is suspended or revoked, no member of that firm or officer or director of the corporation may hold a certificate during the period of the suspension or revocation unless the director determines, based on substantial evidence, that the member, officer or corporation director was not personally at fault.

20-2509. Confidentiality

A. A utilization review agent shall file with the director written procedures for assuring that patient information it obtains during the process of utilization review is maintained as confidential in accordance with applicable federal and state laws, is used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management and is shared only with agencies authorized by the patient in writing and on a form prescribed by the director to receive the information. Summary data are not confidential if the data do not provide sufficient information to allow identification of individual patients. This subsection does not permit a person to obtain information without complying with other requirements of this title.

B. A utilization review agent shall comply with all applicable state and federal laws relating to the confidentiality of medical records.

20-2510. Health care insurers requirements; medical directors

A. A health care insurer that proposes to provide coverage of inpatient hospital and medical benefits, outpatient surgical benefits or any medical, surgical or health care service for residents of this state with utilization review of those benefits shall meet at least one of the following requirements:

1. Have a certificate issued pursuant to this chapter.

2. Be accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

3. Contract with a utilization review agent that has a certificate issued pursuant to this chapter.

4. Contract with a utilization review agent that is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

5. Provide to the director a signed and notarized statement that the health care insurer has submitted an application for accreditation to the utilization review accreditation commission or the national committee for quality assurance and is awaiting completion of the accreditation review process. On completion of the accreditation review process, the insurer shall provide to

the director adequate proof that the insurer has been accredited. If the insurer is denied accreditation, within sixty days after the denial the insurer shall meet at least one of the requirements set forth in paragraph 1, 2, 3 or 4 of this subsection.

B. Except as provided in subsections C, D and E of this section, any direct denial of prior authorization of a service requested by a health care provider on the basis of medical necessity by a health care insurer shall be made in writing by a medical director who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17. The written denial shall include an explanation of why the treatment was denied, and the medical director who made the denial shall sign the written denial. The health care insurer shall send a copy of the written denial to the health care provider who requested the treatment. Health care insurers shall maintain copies of all written denials and shall make the copies available to the department for inspection during regular business hours. The medical director is responsible for all direct denials that are made on the basis of medical necessity. Nothing in this section prohibits a health care insurer from consulting with a licensed physician whose scope of practice may provide the health care insurer with a more thorough review of the medical necessity.

C. For determinations made pursuant to subsection B of this section, a dental service corporation as defined in section 20-822 or a prepaid dental plan organization as defined in section 20-1001 may use as a medical director either:

1. An individual who holds an active unrestricted license to practice dentistry in this state pursuant to title 32, chapter 11.

2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

D. For determinations made pursuant to subsection B of this section, an optometric service corporation may use as a medical director either:

1. An individual who holds an active unrestricted license to practice optometry in this state pursuant to title 32, chapter 16.

2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

E. For determinations made pursuant to subsection B of this section, a health care insurer shall use a chiropractor licensed in this state pursuant to title 32, chapter 8 or by any regulatory board in another state to review any direct denial of prior authorization of a chiropractic service requested by a chiropractor on the basis of medical necessity.

20-2511. Violation; injunctive relief

If the director believes that a utilization review agent is violating or is about to violate section 20-2502, the director may order the agent to cease and desist. The director through the attorney general may file a complaint in the superior court in the county in which the agent transacts

utilization review business to enjoin and restrain the agent from committing or continuing the violation. If the director orders the utilization review agent to cease and desist, the agent may request a hearing pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, seek judicial review pursuant to title 12, chapter 7, article 6. If the director files a complaint through the attorney general the superior court has jurisdiction of the proceeding and may make and enter an order or judgment awarding preliminary or final relief as in its judgment is proper.

Article 2. Health Care Appeals

20-2530. Definitions

For the purposes of this article:

1. "Member" means a person who is covered under a health care plan provided by a health care insurer or that person's treating provider, parent, legal guardian, surrogate who is authorized to make health care decisions for that person by a power of attorney, a court order or the provisions of section 36-3231, or agent who is an adult and who has the authority to make health care treatment decisions for that person pursuant to a health care power of attorney.

2. "Utilization review agent" means those persons and entities that perform utilization review as defined in section 20-2501 and includes any health care insurer whose utilization review plan includes the direct or indirect denial of requested medical or health care services or the denial of claims.

20-2531. Applicability; requirements; exception

A. Notwithstanding article 1 of this chapter and subject to subsection B of this section, this article applies to all utilization review decisions made by utilization review agents and health care insurers operating in this state.

B. Each utilization review agent and each health care insurer operating in this state whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials that do all of the following:

1. Meet the requirements of this article.

2. Are consistent with chapter 1 of this title.

3. Comply with section 20-2505, paragraphs 2 through 6.

C. This article does not apply to utilization review:

1. Performed under contract with the federal government for utilization review of patients eligible for all services under title XVIII of the social security act.

2. Performed by a self-insured or self-funded employee benefit plan or a multiemployer employee benefit plan created in accordance with and pursuant to 29 United States Code section 186(c) if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974 (29 United States Code section 1144(b)), but this article does apply to a health care insurer that provides coverage for services as part of an employee benefit plan.

3. Of work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Performed under the terms of a policy that pays benefits based on the health status of the insured and does not reimburse the cost of or provide covered services.

5. Performed under the terms of a long-term care insurance policy as defined in section 20-1691.

6. Performed under the terms of a medicare supplement policy as defined by the department.

D. This article does not create any new private right or cause of action for or on behalf of any member. This article provides only an administrative process for a member to pursue an external independent review of a denial for a covered service or claim for a covered service.

E. Utilization review activities involving retrospective claims review are limited to the provisions of this article only as clearly and specifically provided in the provisions of this article.

F. The processes available under this article do not apply to a denial of a nonformulary exception request that was appealed pursuant to 45 Code of Federal Regulations section 156.122(c). A provider or enrollee may appeal a denial of a nonformulary exception for a plan covered by 45 Code of Federal Regulations section 156.122(c) through the process prescribed in the federal rule.

20-2532. Utilization review standards and criteria; requirements

A. Each utilization review agent shall:

1. Adopt a written utilization review plan with standards and criteria that apply to all utilization review determinations and that are objective, clinically valid and compatible with established principles of health care.

2. Establish the utilization review plan with input from physician advisors who represent major medical specialties and who are certified or board eligible under the standards of the appropriate American medical specialty board.

3. Include in the adopted utilization review plan a process for prompt initial reconsideration of an adverse determination and a process for appeals that meet the requirements of this article. This paragraph does not apply to utilization review activities limited to retrospective claims review.

B. Deviations from the written standards and criteria in the utilization review plan are allowed if the utilization review agent determines that the member and other members with similar symptoms and diagnoses would materially benefit from new treatments available because of medical or technological advances made since the adoption of the utilization review plan and made in accordance with accepted medical standards. This subsection does not apply to utilization review activities limited to retrospective claims review. Nothing in this subsection

creates a private right or cause of action against a health care insurer or utilization review agent for failure to deviate from the utilization review plan.

C. A health care insurer who uses the services of an outside utilization review agent shall adopt a utilization review plan pursuant to subsections A and B of this section. The utilization review plan adopted and filed by the health care insurer who uses the services of an outside utilization review agent is deemed adopted by that utilization review agent.

D. A health care insurer who uses the services of an outside utilization review agent is responsible for the utilization review agent's acts that are within the scope of the written and filed utilization review plan, including the administration of all patient claims processed by the utilization review agent on behalf of the health care insurer.

E. Each utilization review agent shall file a notice with the director that provides a specific description and the published date of the source of the written standards and criteria of the utilization review plan and that certifies that the utilization review plan in use complies with the requirements of this section, is available for review and inspection at a designated location in this state or at an office accessible to authorized representatives of the director in another state and is the complete utilization review plan with all standards and criteria on which utilization review decisions are based. A copy of any portion of the utilization review plan on which any adverse determinations have been based shall be made before the effective date of any modification and the utilization review agent shall retain a copy at the designated location for review and inspection for a period of five years after the date of the modification. If at any time a complete change in the written standards and criteria occurs, the utilization review agent shall file a new certification notice with the director.

F. On or before March 1 of each year after the year in which the utilization review agent filed the notice prescribed in subsection E of this section, the utilization review agent or the agent's successor shall submit a signed and notarized annual report to the director that includes the designated location for review and inspection by the director or the director's authorized representative and that certifies that:

1. The utilization review plan and all modifications remain in compliance with the requirements of this section.

2. The utilization review agent will conduct all utilization reviews in accordance with the plan.

3. All adverse determinations made in the prior year were based on the plan in effect on the date of those adverse determinations.

G. On written request, the utilization review agent shall provide copies to any member or the member's treating provider of:

1. Those portions of the utilization review agent's utilization review plan that are relevant to the request for a covered service or claim for a covered service.

2. The protocols or guidelines that were used if the standards and criteria adopted are based on protocols or guidelines developed by an American medical specialty board.

H. Any person who requests records pursuant to subsection G of this section shall direct the request to the utilization review agent and not to the department.

I. If the utilization review plan is copyrighted by a person other than the utilization review agent, the health care insurer shall make a good faith effort to obtain permission from that person to make copies of the relevant material. If the health care insurer is unable to secure copyright permission, the utilization review agent shall provide a detailed summary of the relevant portions of the utilization review plan.

J. Health care insurers having utilization review activities limited to retrospective claims review shall be required to adopt only those procedures and sources of review that are traditionally associated with and necessary for retrospective claims review.

20-2533. Denial; levels of review; disclosure; additional time after service by mail; review process

A. No minimum dollar amount may be imposed on any claim that is the subject of an adverse determination for a member to, and any member who receives an adverse determination may, pursue the applicable review process prescribed in this article. Except as provided in sections 20-2534 and 20-2535, health care insurers shall provide at least the following levels of review, as applicable:

1. An expedited medical review and expedited appeal pursuant to section 20-2534.

2. An initial appeal pursuant to section 20-2535.

3. An external independent review pursuant to section 20-2537.

B. For group plans, and for grandfathered individual plans, a health care insurer may elect to offer a voluntary internal appeal pursuant to section 20-2536 as an additional internal level of review after a determination of an initial appeal.

C. For individual plans and group plans for which the health care insurer does not elect to offer a voluntary internal appeal as an internal level of review, the health care insurer shall:

1. With the exception of a denial of a claim for service that has already been provided, send the member a written determination within thirty days after the health care insurer receives the appeal request.

2. For a denial of a claim for service that has already been provided, send the member a written determination within sixty days after the health care insurer receives the appeal request.

D. A health care insurer that elects to offer a voluntary internal appeal for the health care insurer's group plans shall:

1. With the exception of a denial of a claim for service that has already been provided, send the member a written determination within fifteen days after the health care insurer receives the initial appeal request and within fifteen days after the health care insurer receives the voluntary internal appeal request.

2. For a denial of a claim for a service that has already been provided, send the member its written determination within thirty days after the health care insurer receives the health care insurer receives the initial appeal request and within thirty days after the health care insurer receives the voluntary internal appeal request.

E. A health care insurer shall provide a written determination as required by this section and include the basis, criteria used, clinical reasons and rationale for the determination.

F. Except as provided in sections 20-2534 and 20-2537, a member shall be considered to have exhausted a health care insurer's internal levels of review if the health care insurer fails to comply with this article, except to the extent that the member requested or agreed to the delay, and the member may simultaneously initiate an expedited external independent review.

G. Notwithstanding subsection A, paragraph 2 of this section, a health care insurer may waive the internal appeal process.

H. At the time coverage is initiated, each health care insurer that operates in this state and whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall include a separate information packet that is approved by the director with the member's policy, evidence of coverage or similar document. At the time coverage is renewed, each health care insurer shall include a separate statement with the member's policy, evidence of coverage or similar document that informs the member that the member can obtain a replacement packet that explains the appeal process by contacting a specific department and telephone number. A health care insurer shall also provide a copy of the information packet to the member or the member's treating provider on request and shall prominently display a copy of the approved information packet on its website. The information packet provided by the health care insurer shall include all of the following information:

1. A detailed description and explanation of each level of review prescribed in subsections A and B of this section and notice of the member's right to proceed to the next level of review if the prior review is unsuccessful.

2. An explanation of the procedures that the member must follow, including the applicable time periods, for each applicable level of review prescribed in subsections A, B, C and D of this section and an explanation of how the member may obtain the member's medical records pursuant to title 12, chapter 13, article 7.1.

3. The specific title and department of the person and the address, telephone number and fax number or email address of the person whom the member must notify at each applicable level of review prescribed in subsections A and B of this section in order to pursue that level of review.

4. The specific title and department of the person and the address, telephone number and fax number or email address of the person who will be responsible for processing that review.

5. A notice that if the member decides to pursue an appeal the member must provide the person who will be responsible for processing the appeal with any material justification or documentation for the appeal at the time that the member files the written appeal.

6. A description of the utilization review agent's and health care insurer's roles at each applicable level of review prescribed by subsections A, B, C and D of this section and an outline of the director's role during the external independent review process, if not already described in response to paragraph 1 of this subsection.

7. A notice that if the member participates in the process of review pursuant to this article the member waives any privilege of confidentiality of the member's medical records regarding any person who examined or will examine the member's medical records in connection with that review process for the medical condition under review.

8. A statement that the member is not responsible for the costs of any external independent review.

9. Standardized forms that are prescribed by the department and that a member may use to file and pursue an appeal.

10. The name and telephone number for the department of insurance and financial institutions consumer assistance office with a statement that the department of insurance and financial institutions consumer assistance office can assist consumers with questions about the health care appeals process.

I. At the time of issuing a denial, the health care insurer shall notify the member of the right to appeal under this article. A health care insurer that issues an explanation of benefits document shall satisfy this obligation by prominently displaying in the document a statement about the right to appeal. A health care insurer that does not issue an explanation of benefits document shall satisfy this obligation through some other reasonable means to assure that the member is apprised of the right to appeal at the time of a denial. A reasonable means that includes giving the member's treating provider a form statement about the right to appeal shall require the treating provider to notify the member of the member's right to appeal.

J. Any written notice, acknowledgment, request, determination or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing.

K. The director shall require any member who files a complaint with the department relating to an adverse determination to pursue the review process prescribed in this article. This subsection does not limit the director's authority pursuant to chapter 1, article 2 of this title.

L. If the member's complaint involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the claim or service is covered, the initial appeal process shall be performed as prescribed by section 20-2535 by a licensed health care professional. If the member's complaint involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the claim or service is covered, the expedited review or voluntary internal appeal shall be decided by a physician, provider or other health care professional as prescribed by section 20-2534 or 20-2536. Any external independent review shall be decided by a physician, provider or other health care professional as prescribed by section 20-2537.

M. Before a health care insurer makes a final internal adverse determination that relies on new or additional evidence generated directly or indirectly by the health care insurer, the health care insurer shall provide the new or additional information to the member free of charge sufficiently in advance of the final adverse determination to allow the member a reasonable opportunity to respond within the applicable time frames for the health care insurer to provide the member with a written determination prescribed in subsections C and D of this section.

N. Any person given access to a member's medical records or other medical information in connection with proceedings pursuant to this article shall maintain the confidentiality of the records or information in accordance with title 12, chapter 13, article 7.1.

20-2534. Expedited medical review; expedited appeal

A. Except for a denial of a claim for service or a rescission of coverage, any member who receives an adverse determination may pursue an expedited medical review of that denial if the member's treating provider certifies in writing and provides supporting documentation to the utilization review agent that the time period for the initial appeal process prescribed in section 20-2535 and, if applicable, the voluntary internal appeal process prescribed in section 20-2536 are likely to cause a significant negative change in the member's medical condition at issue that is subject to the appeal. The treating provider's certification is not challengeable by the health care insurer. A health care insurer whose utilization review activities consist only of claims review for services already provided is not required to provide its members an expedited medical review or expedited appeal pursuant to this section. A health care insurer who conducts utilization review of claims in connection with services already provided is not required to provide its members an expedited medical review or expedited appeal of a claim related to a service already provided.

B. On receipt of the certification and supporting documentation, the utilization review agent has seventy-two hours to make a determination and send to the member and the member's treating provider a notice of that determination, including the basis, criteria used, clinical reasons and

rationale for that determination and any references to supporting documentation. If the member's complaint involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, before making a determination, the agent shall consult with a physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an out-of-state provider, physician or other health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition under review.

C. If the utilization review agent affirms the denial of the requested service, the agent shall telephonically provide and send to the member and the member's treating provider a notice of the adverse determination and of the member's option to immediately proceed to an expedited appeal pursuant to subsection E of this section.

D. At any time during the expedited appeal process, the utilization review agent may request an expedited external independent review pursuant to section 20-2537. If the utilization review agent initiates an expedited external independent review, the utilization review agent does not have to comply with subsection E of this section.

E. If the member chooses to proceed with an expedited appeal, the member's treating provider shall immediately submit a written appeal of the denial of the service to the utilization review agent and provide the utilization review agent with any additional material justification or documentation to support the member's request for the service. Within three business days after receiving the request for an expedited appeal, the utilization review agent shall provide notice of the expedited appeal determination as prescribed in this subsection. If the member's complaint involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, the utilization review agent shall select a provider who shall review the appeal and render the determination based on the utilization review plan adopted by the utilization review agent. If the utilization review agent or provider denies the expedited appeal, the utilization review agent shall telephonically provide and send to the member and the member's treating provider a notice of the denial and of the member's option to immediately proceed to the external independent review prescribed in section 20-2537. For the purposes of this subsection:

1. "Advanced practice registered nurse" means any of the following as defined in section 32-1601:

(a) A certified nurse midwife.

(b) A certified registered nurse anesthetist.

(c) A clinical nurse specialist.

(d) A registered nurse practitioner.

2. "Provider" means either of the following:

(a) A physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15, who is qualified in a similar scope of practice as a physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 and who is employed or under contract with the utilization review agent.

(b) An out-of-state physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who either is qualified in a similar scope of practice as a physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 or who typically manages the medical condition under appeal.

F. If the utilization review agent, provider, physician or other health care professional concludes that the covered service should be provided, the health care insurer is bound by the utilization review agent's determination.

20-2535. Initial appeal

A. Any member who receives an adverse determination and who does not qualify for an expedited medical review pursuant to section 20-2534 may request, either orally or in writing, an initial appeal of that denial by notifying the person described in section 20-2533, subsection H, paragraph 3. After the denial, the member has up to two years to request an initial appeal.

B. The utilization review agent may request any pertinent medical records pursuant to title 12, chapter 13, article 7.1 that are necessary for the initial appeal.

C. If the member's appeal involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, the utilization review agent shall select a provider to review the appeal and render a determination based on the utilization review plan. For the purposes of this subsection:

1. "Advanced practice registered nurse" means any of the following as defined in section 32-1601:

(a) A certified nurse midwife.

(b) A certified registered nurse anesthetist.

(c) A clinical nurse specialist.

(d) A registered nurse practitioner.

2. "Provider" means either of the following:

(a) A physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15, who is qualified in a similar scope of practice as a physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 and who is employed or under contract with the utilization review agent.

(b) An out-of-state physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who either is qualified in a similar scope of practice as a physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 or who typically manages the medical condition under appeal.

D. Within the time frames prescribed in section 20-2533, subsections C and D, the utilization review agent shall send to the member and the member's treating provider a notice of the utilization review agent's determination and the basis, criteria used, clinical reasons and rationale for that determination.

E. At any time during the initial appeal process, the utilization review agent may submit a request to the director to initiate an external independent review process pursuant to section 20-2537. At the same time that the utilization review agent submits the request to the director, the utilization review agent shall also render a written determination and shall send the written determination, including the basis, criteria used, clinical reasons and rationale for that determination and any references to supporting documentation, to the member, the member's treating provider and the director.

F. If the utilization review agent does not submit a request to the director pursuant to subsection E of this section and at the conclusion of the initial appeal process the utilization review agent denies the covered service or the claim for the covered service, the utilization review agent shall provide the member and the treating provider with a written statement of the agent's decision and the basis, criteria used, clinical reasons and rationale for that determination, including any references to any supporting documentation. The determination shall include a notice of the option to proceed to the voluntary internal appeal process pursuant to section 20-2536 for a group health plan or grandfathered individual plan for which the health care insurer elected to have a voluntary internal appeal level of review or to an external independent review pursuant to section 20-2537 if the health care insurer has only one internal level of review.

G. If the utilization review agent concludes that the covered service should be provided or the claim for a covered service should be paid, the health care insurer is bound by the utilization review agent's determination.

20-2536. Voluntary internal appeal

A. For a group health plan, or a grandfathered individual plan, if a health care insurer elects to include as part of its internal review levels a voluntary internal appeal level after any applicable initial appeal pursuant to section 20-2535 and the utilization review agent denies the member's initial request, the member may appeal that adverse determination to the voluntary internal appeal level. The member shall send a written appeal to the utilization review agent within sixty days after receipt of the adverse determination.

B. The member or the member's treating provider shall submit to the utilization review agent with the written voluntary internal appeal any material justification or documentation to support the member's request for the service or claim for a service.

C. If the member's appeal involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document and not whether the service is covered, the utilization review agent shall select a provider to review the appeal and render a determination based on the utilization review plan adopted by the utilization review agent. For the purposes of this subsection:

1. "Advanced practice registered nurse" means any of the following as defined in section 32-1601:

(a) A certified nurse midwife.

(b) A certified registered nurse anesthetist.

(c) A clinical nurse specialist.

(d) A registered nurse practitioner.

2. "Provider" means either of the following:

(a) A physician or other health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15, who is qualified in a similar scope of practice as a physician or other health care professional licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 and who is employed or under contract with the utilization review agent.

(b) An out-of-state physician or other health care professional who is licensed in another state and who is not licensed in this state, who is employed or under contract with the utilization review agent and who either is qualified in a similar scope of practice as a physician or other health care professional Licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an advanced practice registered nurse who is licensed pursuant to title 32, chapter 15 or who typically manages the medical condition under appeal.

D. Except as provided in subsection E of this section, the utilization review agent shall send to the member and the member's treating provider a notice of the utilization review agent's determination and the basis, criteria used, clinical reasons and rationale for that determination within the time frames prescribed in section 20-2533, subsection D.

E. At any time during the voluntary internal appeal process, the utilization review agent may request an external independent review process pursuant to section 20-2537. If the utilization review agent initiates the external independent review process, the utilization review agent does not have to comply with subsection d of this section.

F. If at the conclusion of the voluntary internal appeal process the utilization review agent denies the appeal and the utilization review agent does not initiate the external independent review process, the utilization review agent shall provide the member with notice of the option to proceed to an external independent review pursuant to section 20-2537.

G. If the utilization review agent concludes that the covered service should be provided or the claim for a covered service should be paid, the health care insurer is bound by the utilization review agent's determination.

20-2537. External independent review; expedited external independent review

(Conditionally Rpld.)

A. If the utilization review agent denies the member's request for a covered service or claim for a covered service at all applicable internal levels of review or if the member has exhausted the health care insurer's internal levels of review pursuant to section 20-2533, subsection F, the member may initiate an external independent review.

B. Except as provided in subsection N of this section, a member may initiate an external independent review within four months after the member receives written notice by the utilization review agent of an adverse determination made pursuant to section 20-2534 or 20-2536 by sending to the utilization review agent a written request for an external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service.

C. Except as provided in subsection N of this section, within five business days after the utilization review agent receives a request for an external independent review from the member pursuant to subsection B of this section or the director pursuant to subsection J of this section, or if the utilization review agent initiates an external independent review pursuant to section 20-2536, subsection F, the utilization review agent shall:

1. Send a written acknowledgment to the director, the member, the member's treating provider and the health care insurer. The acknowledgement shall include notice to the member that the member has five business days after receiving the notice to submit additional written evidence to the department for consideration by the assigned independent review organization.

2. Forward to the director the request for review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the determination pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's determination, the basis, criteria used, clinical reasons and rationale for that determination, the relevant portions of the utilization review agent's utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2533, subsection L.

D. Except as provided in subsection N of this section, within five days after the director receives all of the information prescribed in subsection C, paragraph 2 of this section and if the case involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by subsection C, paragraph 2 of this section.

E. Within one business day after the director receives additional written evidence submitted by the member pursuant to subsection C, paragraph 1 of this section, the director shall provide a copy of the evidence to the health care insurer and the independent review organization. The independent review organization shall consider the evidence in making its determination and in its discretion may consider evidence submitted after five business days.

F. Except as provided in subsection N of this section, for cases involving an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational under the coverage document, within twenty-one days after the date of receiving a case for independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a determination that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary or appropriate, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational and send the determination to the director.

G. The independent review organization's determination pursuant to subsection F of this section shall be consistent with the utilization review plan and in accordance with the following:

1. The independent review organization reviewer shall consider the following information in rendering a determination, as appropriate and available under the circumstances:

(a) The member's pertinent medical records.

(b) The treating provider's recommendation.

(c) Any consulting report from a health care professional.

(d) Any document submitted by a health care insurer or member.

(e) For claims or requests for services denied for reasons other than as experimental or investigational, the independent review organization shall also consider:

(i) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations.

(ii) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

(iii) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (a) through (d) and subdivision (e), items (i) and (ii) of this paragraph to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) For claims or requests for services denied as experimental or investigational, the independent review organization shall also consider the terms of coverage under the member's policy with the health care insurer to ensure that except for a health care insurer's determination for an experimental or investigational service, the reviewer's opinion is not contrary to the terms of coverage and any of the following:

(i) Whether the service has been approved by the United States food and drug administration for the condition.

(ii) Whether the medical or scientific evidence or evidence-based standards demonstrate that the expected benefit of the service is more likely than not to be beneficial to the member than any available standard service and that any adverse risk is not substantially increased over adverse risks of available standard services.

2. The independent review organization reviewer's written determination shall include:

(a) A description of the covered person's medical condition.

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the expected benefit of the service is more likely than not to be beneficial to the member than any available standard service and that any adverse risk is not substantially increased over adverse risks of available standard services.

(c) A description and analysis of any medical or scientific evidence considered in reaching the determination.

(d) A description and analysis of any evidence-based standard.

(e) Information on whether the reviewer's rationale for the determination is based on paragraph 1, subdivision (e), items (i) and (ii) of this subsection.

H. Within five business days after receiving a notice of determination from the independent review organization, the director shall send notice of the determination to the utilization review agent, the health care insurer, the member and the member's treating provider. The determination is a final administrative decision pursuant to title 41, chapter 6, article 10 and is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for a case under review without delay regardless of whether judicial review is sought.

I. Except as provided in subsection N of this section, for cases involving an issue of coverage, within fifteen business days after receipt of all of the information prescribed in subsection C, paragraph 2 of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse determination made pursuant to section 20-2536 conforms to the utilization review agent's utilization review plan and this article and shall send a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

J. If the director finds that the case involves a medical issue or is unable to determine issues of coverage, the director shall submit the member's case to the external independent review organization in accordance with subsections F and N of this section.

K. After a determination is made pursuant to subsection F, I, J or N of this section, the appeals and administrative processes are completed and the department's role is ended, except:

1. To transmit, when necessary, a record of the proceedings to superior court or to the office of administrative hearings.

2. To issue a final administrative decision pursuant to section 41-1092.08.

L. Except as provided in subsection N of this section, on written request by the independent review organization, the member or the utilization review agent, the director may extend the twenty-one day time period prescribed in subsection F of this section for up to an additional ten days if the requesting party demonstrates good cause for an extension.

M. A determination made by the director or an independent review organization pursuant to this section is admissible in proceedings involving a health care insurer or utilization review agent.

N. If the utilization review agent denies the member's request for a covered service or claim for a covered service at the expedited medical review level presented and resolved pursuant to section 20-2534, subsections A and E, denies a health care service for which the member received emergency services but has not been discharged or denies, reduces or terminates coverage for a member's admission, the availability of care, a continued stay for a course of treatment before the end of the period of time or number of treatments recommended by the treating provider, or if a

member exhausted or the health care insurer has waived the health care insurer's internal levels of review pursuant to section 20-2533, subsections F and G, the member may initiate an expedited external independent review in accordance with the following:

1. Within four months after the member receives written notice by the utilization review agent of the adverse determination made pursuant to section 20-2534, if the member decides to initiate an external independent review, the member shall send to the utilization review agent a written request for an expedited external independent review, including any material justification or documentation to support the member's request for the covered service or claim for a covered service. For an adverse determination involving an experimental or investigational service, a member may make an oral request if the member's treating physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated.

2. Within one business day after the utilization review agent receives a request for an expedited external independent review from the member pursuant to this subsection or if the utilization review agent initiates an expedited external independent review pursuant to section 20-2534, subsection D, the utilization review agent shall:

(a) Send a written acknowledgment to the director, the member, the member's treating provider and the health care insurer.

(b) Forward to the director the request for an expedited independent external review, the terms of agreement in the member's policy, evidence of coverage or a similar document and all medical records and supporting documentation used to render the determination pertaining to the member's case, a summary description of the applicable issues including a statement of the utilization review agent's determination, the basis, criteria used clinical reasons and rationale for that determination, the relevant portions of the utilization review agent's utilization review plan and the name and credentials of the licensed health care provider who reviewed the case as required by section 20-2534, subsection B.

3. Within two business days after the director receives all of the information prescribed in this subsection and if the case involves an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational, the director shall choose an independent review organization procured pursuant to section 20-2538 and forward to the organization all of the information required by this subsection.

4. For cases involving an issue of medical necessity or appropriateness, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational, within seventy-two hours from the date of receiving a case for expedited external independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a determination that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary or appropriate, including health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational and send the determination to the director. Within one business day after receiving a notice of determination

from the independent review organization, the director shall send a notice of the determination to the utilization review agent, the health care insurer, the member and the member's treating provider. The determination by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.

5. For cases involving an issue of coverage, within two business days after receipt of all of the information prescribed in subsection C of this section from the utilization review agent, the director shall determine if the service or claim is or is not covered and if the adverse determination made pursuant to section 20-2534 conforms to the utilization review agent's utilization review plan and this article and shall send a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

O. Notwithstanding title 41, chapter 6, article 10 and section 12-908, if a party to a decision issued under this section seeks further administrative review, the department shall not be a party to the action unless the department files a motion to intervene in the action.

P. The independent review organization, the director or the office of administrative hearings may not order the health care insurer to provide a service or to pay a claim for a benefit or service that is excluded from coverage by the contract.

Q. The health care insurer shall provide any service or pay any claim determined in a final administrative decision to be covered and medically necessary for the case under review regardless of whether judicial review is sought. Any proceedings before the office of administrative hearings that involve an expedited external independent review and that are subject to subsection N of this section shall be promptly instituted and completed.

20-2538. Independent review organizations

A. Pursuant to title 41, chapter 23, the director shall procure as many independent review organizations as necessary and practicable to perform the independent medical reviews described in section 20-2537.

B. Through the procurement process the director shall ensure that any procured independent review organization uses physicians or other health care professionals who are licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 17, 19, 19.1 or 29 or out of state physicians or other health care professionals who are licensed in another state and who are not licensed in this state, who are board certified or board eligible by the appropriate American medical specialty board and who are in the same or a similar scope of practice as a physician or another health care professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 17, 19, 19.1 or 29 or an out of state physician or another health care professional who is licensed in another state and who is not licensed in this state and who typically manages the medical condition, procedure or treatment under review.

C. The independent review organization and its individual reviewer shall not have a substantial interest in the member, provider or health care insurer involved in the particular case under review or any other conflict of interest that will preclude the reviewer from making a fair and impartial decision. The individual reviewer shall not be a policyholder or insured member of a company whose case is being reviewed.

D. An out of state physician or another health care professional who is licensed in another state and who is not licensed in this state in a field substantially similar to the laws of this state applicable to physicians or other health care professionals who are licensed under title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 and who are certified or board eligible by the appropriate American medical specialty board may serve as an independent reviewer for the procured independent review organization and that provider's analysis, assessment or decision for the independent review organization does not constitute the practice of medicine or any other health care profession in this state.

E. The director, any procured independent review organization or any independent reviewer acting in good faith is not liable for the analysis, assessment or decision of any case reviewed pursuant to this article.

20-2539. Rules

The director may adopt rules pursuant to title 41, chapter 6 to carry out this article.

20-2540. Health care appeals fund

A. The health care appeals fund is established consisting of monies collected pursuant to subsection B of this section. The fund is a special state fund pursuant to section 35-142, subsection A, paragraph 8. Monies in the fund do not revert to the state general fund. The department shall administer the fund. Monies in the fund are continuously appropriated and are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

B. The director shall charge an appealing member's health care insurer for all amounts owed to the independent review organization, pursuant to subsection C of this section, to decide the member's appeal. The director may assess each health care insurer for administrative costs for implementing and maintaining the external independent review process as prescribed in this section and section 20-2538. The director shall deposit all collected monies in the fund.

C. The director shall use monies in the fund to:

1. Compensate procured independent review organizations for performing independent medical reviews on a per case rate unless the director determines that another method is necessary to carry out the purposes of this article.

2. Perform the responsibilities relating to the procurement of independent review organizations and to implement and maintain the external independent review process.

D. An independent review organization shall submit to the director for approval a detailed invoice consistent with the method of payment prescribed in subsection C of this section.

20-2541. Health care insurer fee

The director may assess each health care insurer that is authorized to transact insurance:

1. A single fee of not more than $200 per insurer.

2. Up to $200 each year for the costs of performing the responsibilities relating to the procurement of independent review organizations as prescribed in sections 20-2537 and 20-2538 and for implementing and maintaining the external independent review process, including processing and paying claims through the health care appeals fund established by section 20-2540. The department is authorized one full-time equivalent position to perform these responsibilities.

20-2542. Recordkeeping

A health care insurer and an independent review organization shall maintain all records related to internal and external appeals and exception requests for at least three years after the completion of the appeals process or exception request process.

Chapter 21. Health Care Insurer Liability

Article 1. General Provisions

20-3151. Definitions

For the purposes of this section:

1. "Enrollee" means an individual who is enrolled in a health care plan provided by a health care insurer.

2. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation.

3. "Health care plan" means a policy, contract or evidence of coverage issued to an enrollee. Health care plan does not include limited benefit coverage as defined in section 20-1137.

4. "Health care professional" means a professional who is regulated pursuant to title 32, chapter 7, 8, 11, 13, 14, 15, 15.1, 16, 17, 18, 19, 19.1, 25, 28, 29, 33, 34, 35, 39 or 41, title 36, chapter 6, article 7 or title 36, chapter 17.

Chapter 25. Pharmacy Benefits

Article 1. Auditing

20-3321. Definitions

In this chapter, unless the context otherwise requires:

1. "Auditing entity" means any person, company, group or plan working on behalf of or pursuant to a contract with an insurer or pharmacy benefits manager for the purposes of auditing pharmacy drug claims adjudicated by pharmacies.

2. "Clerical errors" means a minor recordkeeping or transcribing error, including typographical errors, scrivner's errors or computer errors, in a required electronic or hard copy document, record or prescription order if both of the following criteria are met:

(a) The error did not result in actual financial harm to an entity.

(b) The error did not involve dispensing an incorrect dose or type of medication or dispensing a prescription drug to the wrong person.

3. "Desktop audit" means an audit that is conducted by an auditing entity at a location other than the location of the pharmacist or pharmacy. Desktop audit includes an audit that is performed at the offices of the auditing entity during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk or other electronic media.

4. "In-pharmacy audit" means an audit that is conducted by an auditing entity at the physical business address of the pharmacy where the claim was adjudicated.

5. "Insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation.

6. "List" means the list of drugs for which a pharmacy benefit manager has established a maximum allowable cost.

7. "Maximum allowable cost":

(a) Means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a multisource drug.

(b) Does not include the dispensing fee for the drug.

8. "Pharmacist" has the same meaning prescribed in section 32-1901.

9. "Pharmacy" has the same meaning prescribed in section 32-1901.

10. "Pharmacy benefit manager" means a person, business or other entity that, pursuant to a contract or under an employment relationship with an insurer or other third-party payor, either directly or through an intermediary manages the prescription drug coverage provided by the insurer or other third-party payor, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies and controlling the cost of covered prescription drugs.

Article 2. Pharmacy Benefit Managers

20-3333. Certificates of authority; issuance; revocation; renewal; civil penalties; rules

A. A pharmacy benefit manager shall apply for, obtain and maintain a valid certificate of authority to operate as a pharmacy benefit manager in this state. A certificate of authority is renewable biennially and is nontransferable.

B. A pharmacy benefit manager that applies for a certificate of authority shall submit to the director both of the following:

1. An application in a form and manner prescribed by the director. An officer or individual who is responsible for the conduct of the activities of the pharmacy benefit manager shall sign the application and verify that the contents of the application and any attachments are correct. The application form shall include the following:

(a) The name, address and telephone number of the pharmacy benefit manager.

(b) A copy of all basic organizational documents of the pharmacy benefit manager, including the articles of incorporation, bylaws, articles of association and trade name certificate, any other similar documents and all amendments to the documents.

(c) The name and address of the pharmacy benefit manager's agent in this state for service of process.

(d) The names, addresses, official positions and professional qualifications of each individual who is responsible for the conduct of the activities of the pharmacy benefit manager.

(e) The name, address, telephone number, email address and official position of the employee who will serve as the primary contact for the department.

(f) A signed certificate of good standing.

(g) A description of the pharmacy benefit manager and its services, facilities and personnel.

(h) A document in which the pharmacy benefit manager confirms that its business practices and each ongoing Arizona contract comply with this article and all laws of this state.

2. An application fee prescribed by the director.

C. Within ninety days after receipt of a completed application and application fee, the director shall review the application and issue a certificate of authority if the applicant is deemed qualified under this section. If the director determines that the applicant is not qualified, the director shall notify the applicant, shall specify the reason for the denial and shall allow the applicant sixty days to remedy the stated reasons for the denial.

D. Within thirty days after any material modification of the information submitted with the application for a certificate of authority, the pharmacy benefit manager shall file a notice of modification with the director.

E. The director may refuse to issue a certificate of authority if the director determines that the pharmacy benefit manager had a pharmacy benefit manager certificate of authority or license revoked for cause in another state.

F. The director may issue a cease and desist order if the pharmacy benefit manager does not hold a valid certificate of authority. The director may deny, suspend or revoke a pharmacy benefit manager's certificate of authority if the director finds, after notice and opportunity for hearing, that any of the following applies:

1. The pharmacy benefit manager violated any rule or order of the director or any law of this state applicable to a pharmacy benefit manager.

2. The pharmacy benefit manager refused to be examined or to produce its accounts, records and files for examination or that any individual responsible for the conduct of the activities in this state of the pharmacy benefit manager refused to provide information with respect to its activities or refused to perform any other legal obligation required by the director.

3. The pharmacy benefit manager is required under this section to have a certificate of authority and fails at any time to meet any qualification for which issuance of a certificate of authority could have been refused had the failure existed at the time of issuance and been known to the director, unless the director issued a certificate of authority with knowledge of the ground for disqualification and had the authority to waive it.

4. Any individual who is responsible for the management of the pharmacy benefit manager is convicted of or enters a plea of guilty or no contest to a felony related to the individual's activities on behalf of the pharmacy benefit manager.

5. The pharmacy benefit manager's certificate of authority or license has been revoked in another state.

G. If a pharmacy benefit manager's certificate of authority is suspended or restricted, the director may allow the operation of the pharmacy benefit manager for a limited time not to exceed one hundred twenty days. The director may allow a pharmacy benefit manager whose certificate of authority has been suspended or restricted to operate for a period that exceeds one hundred twenty days if the director determines that the continued operation of the pharmacy benefit manager is in the beneficial interests of the covered persons by ensuring minimal disruptions to the continuity of care. A pharmacy benefit manager whose certificate of authority has been suspended or restricted is subject to the following civil penalties each month, as determined by the director, until the pharmacy benefit manager remedies the violation:

1. For an unintentional violation, not more than $1,000 for each violation and not more than an aggregate of $10,000 in any six month period.

2. For an intentional violation, not more than $5,000 for each violation and not more than an aggregate of $50,000 in any six month period.

H. The director may revoke the certificate of authority if the pharmacy benefit manager has been operating under a suspended certificate of authority for a period of more than one hundred twenty days.

I. For the purposes of this section, a pharmacy benefit manager has the same rights to notice and a hearing prescribed in title 41, chapter 6, article 10.

J. The director may investigate officers, directors and owners of a pharmacy benefit manager to comply with this section.

K. To renew a certificate of authority, a pharmacy benefit manager shall submit to the director all of the following:

1. A renewal application in a form and manner prescribed by the director. An officer or authorized representative of the pharmacy benefit manager shall sign the application and verify that the contents of the renewal form are correct.

2. A renewal schedule and a fee prescribed by the director.

L. A pharmacy benefit manager's certificate of authority expires by operation of law if a complete renewal application and fee is not received by the due date as established in rule.

M. If a pharmacy benefit manager and an insurer enter into a contractual agreement, the pharmacy benefit manager shall comply with the laws and rules that govern the contractual agreement as of the date of issuance of the certificate of authority.

N. A pharmacy benefit manager shall comply with the records retention schedules as prescribed in rule and section 20-3334.

O. A pharmacy benefit manager shall comply with the duties and appeals processes of a utilization review agent as prescribed by rule and chapter 15 of this title.

P. The director may examine or review the relevant books and records of a pharmacy benefit manager to determine if the pharmacy benefit manager is in compliance with this article. All of the following apply to the information or data that is obtained during an examination or review:

1. The information is considered and treated as proprietary and confidential.

2. The information is not a public record and is exempt from title 39, chapter 1.

3. The information is to be used only for the purpose of ensuring a pharmacy benefit manager's compliance with this article.

Q. The director may adopt rules to implement this section.

R. This section shall apply only to a pharmacy benefit manager performing services for a health plan subject to the jurisdiction of this state.

S. This section does not apply to a workers' compensation insurer performing services under title 23.

20-3334. Records retention; schedule

A. The director shall establish a retention schedule for all records, books, documentation and other data on file with the department related to the enforcement of this article.

B. The director shall not order the destruction or other disposal of any record, book, document or other data that is:

1. Required by law to be maintained.

2. Kept on file with the department until ten years have passed.

3. Filed during the director's administration or administrations.

C. All of the following apply to the records, books, documentation and other data obtained by the department:

1. The information is considered and treated as proprietary and confidential.

2. The information is not a public record and is exempt from title 39, chapter 1.

3. The information is to be used only for the purpose of ensuring the pharmacy benefit manager's compliance with this article.

Title 41. State Government

Chapter 6. Administrative Procedure

Article 3. Rulemaking

41-1032. Effective date of rules

A. A rule filed pursuant to section 41-1031 becomes effective sixty days after a certified original and two copies of the rule and preamble are filed in the office of the secretary of state and the time and date are affixed as provided in section 41-1031, unless the rule making agency includes in the preamble information that demonstrates that the rule needs to be effective immediately on filing in the office of the secretary of state and the time and date are affixed as provided in section 41-1031. A rule may only be effective immediately for any of the following reasons:

1. To preserve the public peace, health or safety.

2. To avoid a violation of federal law or regulation or state law, if the need for an immediate effective date is not created due to the agency's delay or inaction.

3. To comply with deadlines in amendments to an agency's governing statute or federal programs, if the need for an immediate effective date is not created due to the agency's delay or inaction.

4. To provide a benefit to the public and a penalty is not associated with a violation of the rule.

5. To adopt a rule that is less stringent than the rule that is currently in effect and that does not have an impact on the public health, safety, welfare or environment, or that does not affect the public involvement and public participation process.

B. Notwithstanding subsection A of this section, a rule making agency may specify an effective date more than sixty days after the filing of the rule in the office of the secretary of state if the agency determines that good cause exists for and the public interest will not be harmed by the later date.

C. This section does not affect the validity of an existing rule until the new or amended rule that is filed with the secretary of state is effective pursuant to this section.

Article 5. Governor’s Regulatory Review Council

41-1052. Council review and approval; rule expiration

A. Before filing a final rule subject to this section with the secretary of state, an agency shall prepare, transmit to the council and the committee and obtain the council's approval of the rule and its preamble and economic, small business and consumer impact statement that meets the requirements of section 41-1055. The office of economic opportunity shall prepare the economic, small business and consumer impact statement.

B. The council shall accept an early review petition of a proposed rule, in whole or in part, if the proposed rule is alleged to violate any of the criteria prescribed in subsection D of this section and if the early petition is filed by a person who would be adversely impacted by the proposed rule. The council may determine whether the proposed rule, in whole or in part, violates any of the criteria prescribed in subsection D of this section.

C. Within one hundred twenty days after receipt of the rule, preamble and economic, small business and consumer impact statement, the council shall review and approve or return, in whole or in part, the rule, preamble or economic, small business and consumer impact statement. An agency may resubmit a rule, preamble or economic, small business and consumer impact statement if the council returns the rule, economic, small business and consumer impact statement or preamble, in whole or in part, to the agency.

D. The council shall not approve the rule unless:

1. The economic, small business and consumer impact statement contains information from the state, data and analysis prescribed by this article.

2. The economic, small business and consumer impact statement is generally accurate.

3. The probable benefits of the rule outweigh within this state the probable costs of the rule and the agency has demonstrated that it has selected the alternative that imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

4. The rule is written in a manner that is clear, concise and understandable to the general public.

5. The rule is not illegal, inconsistent with legislative intent or beyond the agency's statutory authority and meets the requirements prescribed in section 41-1030.

6. The agency adequately addressed, in writing, the comments on the proposed rule and any supplemental proposals.

7. The rule is not a substantial change, considered as a whole, from the proposed rule and any supplemental notices.

8. The preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rule.

9. The rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law.

10. If a rule requires a permit, the permitting requirement complies with section 41-1037.

E. The council shall verify that a rule with new fees does not violate section 41-1008. The council shall not approve a rule that contains a fee increase unless two-thirds of the voting quorum present votes to approve the rule.

F. The council shall verify that a rule with an immediate effective date complies with section 41-1032. The council shall not approve a rule with an immediate effective date unless two-thirds of the voting quorum present votes to approve the rule.

G. If the rule relies on scientific principles or methods, including a study disclosed pursuant to subsection D, paragraph 8 of this section, and a person submits an analysis to the council questioning whether the rule is based on valid scientific or reliable principles or methods, the council shall not approve the rule unless the council determines that the rule is based on valid scientific or reliable principles or methods that are specific and not of a general nature. In making a determination of reliability or validity, the council shall consider the following factors as applicable to the rule:

1. The authors of the study, principle or method have subject matter knowledge, skill, experience, training and expertise.

2. The study, principle or method is based on sufficient facts or data.

3. The study is the product of reliable principles and methods.

4. The study and its conclusions, principles or methods have been tested or subjected to peer reviewed publications.

5. The known or potential error rate of the study, principle or method has been identified along with its basis.

6. The methodology and approach of the study, principle or method are generally accepted in the scientific community.

H. The council may require a representative of an agency whose rule is under examination to attend a council meeting and answer questions. The council may also communicate to the agency its comments on any rule, preamble or economic, small business and consumer impact statement and require the agency to respond to its comments in writing.

I. At any time during the thirty days immediately following receipt of the rule, a person may submit written comments to the council that are within the scope of subsection D, E, F or G of this section. The council may allow testimony at a council meeting within the scope of subsection D, E, F or G of this section.

J. If the agency makes a good faith effort to comply with the requirements prescribed in this article and has explained in writing the methodology used to produce the economic, small business and consumer impact statement, the rule may not be invalidated after it is finalized on the ground that the contents of the economic, small business and consumer impact statement are insufficient or inaccurate or on the ground that the council erroneously approved the rule, except as provided by section 41-1056.01.

K. The absence of comments pursuant to subsection D, E, F or G of this section or article 4.1 of this chapter does not prevent the council from acting pursuant to this section.

L. The council shall review and approve or reject a notice of proposed expedited rulemaking pursuant to section 41-1027.

M. An agency that seeks to expire a rule or rules may file a notice of intent to expire with the council. The notice shall describe the rule or rules to be expired and the reasons for expiration. The council shall place the notice on the agenda for the next scheduled council meeting for consideration. If a quorum of the council approves the notice, the council shall cause a notice of rule expiration to be prepared and provide the notice of rule expiration to the agency for filing with the secretary of state.

Article 7.1. Licensing Timeframes

41-1072. Definitions

In this article, unless the context otherwise requires:

1. "Administrative completeness review time frame" means the number of days from agency receipt of an application for a license until an agency determines that the application contains all components required by statute or rule, including all information required to be submitted by other government agencies. The administrative completeness review time frame does not include the period of time during which an agency provides public notice of the license application or performs a substantive review of the application.

2. "Overall time frame" means the number of days after receipt of an application for a license during which an agency determines whether to grant or deny a license. The overall time frame consists of both the administrative completeness review time frame and the substantive review time frame.

3. "Substantive review time frame" means the number of days after the completion of the administrative completeness review time frame during which an agency determines whether an application or applicant for a license meets all substantive criteria required by statute or rule. Any public notice and hearings required by law shall fall within the substantive review time frame.

41-1073. Time frames; exception

A. No later than December 31, 1998, an agency that issues licenses shall have in place final rules establishing an overall time frame during which the agency will either grant or deny each type of license that it issues. Agencies shall submit their overall time frame rules to the governor's regulatory review council pursuant to the schedule developed by the council. The council shall schedule each agency's rules so that final overall time frame rules are in place no later than December 31, 1998. The rule regarding the overall time frame for each type of license shall state separately the administrative completeness review time frame and the substantive review time frame.

B. If a statutory licensing time frame already exists for an agency but the statutory time frame does not specify separate time frames for the administrative completeness review and the substantive review, by rule the agency shall establish separate time frames for the administrative completeness review and the substantive review, which together shall not exceed the statutory overall time frame. An agency may establish different time frames for initial licenses, renewal licenses and revisions to existing licenses.

C. The submission by the department of environmental quality of a revised permit to the United States environmental protection agency in response to an objection by that agency shall be given the same effect as a notice granting or denying a permit application for licensing time frame

purposes. For the purposes of this subsection, "permit" means a permit required by title 49, chapter 2, article 3.1 or section 49-426.

D. In establishing time frames, agencies shall consider all of the following:

1. The complexity of the licensing subject matter.

2. The resources of the agency granting or denying the license.

3. The economic impact of delay on the regulated community.

4. The impact of the licensing decision on public health and safety.

5. The possible use of volunteers with expertise in the subject matter area.

6. The possible increased use of general licenses for similar types of licensed businesses or facilities.

7. The possible increased cooperation between the agency and the regulated community.

8. Increased agency flexibility in structuring the licensing process and personnel.

E. This article does not apply to licenses issued either:

1. Pursuant to tribal state gaming compacts.

2. Within seven days after receipt of initial application.

3. By a lottery method.

41-1074. Compliance with administrative completeness review time frame

A. An agency shall issue a written notice of administrative completeness or deficiencies to an applicant for a license within the administrative completeness review time frame.

B. If an agency determines that an application for a license is not administratively complete, the agency shall include a comprehensive list of the specific deficiencies in the written notice provided pursuant to subsection A of this section. If the agency issues a written notice of deficiencies within the administrative completeness time frame, the administrative completeness review time frame and the overall time frame are suspended from the date the notice is issued until the date that the agency receives the missing information from the applicant.

C. If an agency does not issue a written notice of administrative completeness or deficiencies within the administrative completeness review time frame, the application is deemed administratively complete. If an agency issues a timely written notice of deficiencies, an application is not complete until the agency receives all requested information.

D. Except for an application submitted to the department of water resources pursuant to title 45, a determination by an agency that an application is not administratively complete is an appealable agency action, which if timely initiated, entitles the applicant to an adjudication on the merits of the administrative completeness of the application.

41-1075. Compliance with substantive review time frame

A. During the substantive review time frame, an agency may make one comprehensive written request for additional information. The agency and applicant may mutually agree in writing to allow the agency to submit supplemental requests for additional information. If an agency issues a comprehensive written request or a supplemental request by mutual written agreement for additional information, the substantive review time frame and the overall time frame are suspended from the date the request is issued until the date that the agency receives the additional information from the applicant.

B. By mutual written agreement, an agency and an applicant for a license may extend the substantive review time frame and the overall time frame. An extension of the substantive review time frame and the overall time frame may not exceed twenty-five per cent of the overall time frame.

41-1076. Compliance with overall time frame

Unless an agency and an applicant for a license mutually agree to extend the substantive review time frame and the overall time frame pursuant to section 41-1075, an agency shall issue a written notice granting or denying a license within the overall time frame to an applicant. If an agency denies an application for a license, the agency shall include in the written notice at least the following information:

1. Justification for the denial with references to the statutes or rules on which the denial is based.

2. An explanation of the applicant's right to appeal the denial. The explanation shall include the number of days in which the applicant must file a protest challenging the denial and the name and telephone number of an agency contact person who can answer questions regarding the appeals process.

41-1077. Consequence for agency failure to comply with overall time frame; refund; penalty

A. If an agency does not issue to an applicant the written notice granting or denying a license within the overall time frame or within the time frame extension pursuant to section 41-1075, the agency shall refund to the applicant all fees charged for reviewing and acting on the application for the license and shall excuse payment of any such fees that have not yet been paid. The agency shall not require an applicant to submit an application for a refund pursuant to this subsection. The refund shall be made within thirty days after the expiration of the overall time frame or the time frame extension. The agency shall continue to process the application subject to subsection B of this section. Notwithstanding any other statute, the agency shall make the

refund from the fund in which the application fees were originally deposited. This section applies only to license applications that were subject to substantive review.

B. Except for license applications that were not subject to substantive review, the agency shall pay a penalty to the state general fund for each month after the expiration of the overall time frame or the time frame extension until the agency issues written notice to the applicant granting or denying the license. The agency shall pay the penalty from the agency fund in which the application fees were originally deposited. The penalty shall be two and one-half per cent of the total fees received by the agency for reviewing and acting on the application for each license that the agency has not granted or denied on the last day of each month after the expiration of the overall time frame or time frame extension for that license.

41-1079. Information required to be provided

A. An agency that issues licenses shall provide the following information to an applicant at the time the applicant obtains an application for a license:

1. A list of all of the steps the applicant is required to take in order to obtain the license.

2. The applicable licensing time frames.

3. The name and telephone number of an agency contact person who can answer questions or provide assistance throughout the application process.

B. This section does not apply to the Arizona peace officer standards and training board established by section 41-1821.

Article 10. Uniform Administrative Hearing Procedures

41-1092. Definitions

In this article, unless the context otherwise requires:

1. "Administrative law judge" means an individual or an agency head, board or commission that sits as an administrative law judge, that conducts administrative hearings in a contested case or an appealable agency action and that makes decisions regarding the contested case or appealable agency action.

2. "Administrative law judge decision" means the findings of fact, conclusions of law and recommendations or decisions issued by an administrative law judge.

3. "Adversely affected party" means:

(a) An individual who both:

(i) Provides evidence of an actual injury or economic damage that the individual has suffered or will suffer as a direct result of the action and not due to being a competitor or a general taxpayer.

(ii) Timely submits comments on the license application that include, with sufficient specificity, the questions of law, if applicable, that are the basis for the appeal.

(b) A group or association that identifies, by name and physical address in the notice of appeal, a member of the group or association who would be an adversely affected party in the individual's own right.

4. "Appealable agency action" means an action that determines the legal rights, duties or privileges of a party, including the administrative completeness of an application other than an application submitted to the department of water resources pursuant to title 45, and that is not a contested case. Appealable agency actions do not include interim orders by self-supporting regulatory boards, rules, orders, standards or statements of policy of general application issued by an administrative agency to implement, interpret or make specific the legislation enforced or administered by it or clarifications of interpretation, nor does it mean or include rules concerning the internal management of the agency that do not affect private rights or interests. For the purposes of this paragraph, administrative hearing does not include a public hearing held for the purpose of receiving public comment on a proposed agency action.

5. "Director" means the director of the office of administrative hearings.

6. "Final administrative decision" means a decision by an agency that is subject to judicial review pursuant to title 12, chapter 7, article 6.

7. "Licensee":

(a) Means any individual or business entity that has been issued a license by a state agency to engage in any business or activity in this state and that is subject to a licensing decision.

(b) Includes any individual or business entity that has applied for such a license and that appeals a licensing decision pursuant to section 41-1092.08 or 41-1092.12.

8. "Office" means the office of administrative hearings.

9. "Self-supporting regulatory board" means any of the following:

(a) The Arizona state board of accountancy.

(b) The barbering and cosmetology board.

(c) The board of behavioral health examiners.

(d) The Arizona state boxing and mixed martial arts commission.

(e) The state board of chiropractic examiners.

(f) The state board of dental examiners.

(g) The Arizona game and fish commission.

(h) The board of homeopathic and integrated medicine examiners.

(i) The Arizona medical board.

(j) The naturopathic physicians medical board.

(k) The Arizona state board of nursing.

(l) The board of examiners of nursing care institution administrators and assisted living facility managers.

(m) The board of occupational therapy examiners.

(n) The state board of dispensing opticians.

(o) The state board of optometry.

(p) The Arizona board of osteopathic examiners in medicine and surgery.

(q) The Arizona peace officer standards and training board.

(r) The Arizona state board of pharmacy.

(s) The board of physical therapy.

(t) The state board of podiatry examiners.

(u) The state board for private postsecondary education.

(v) The state board of psychologist examiners.

(w) The board of respiratory care examiners.

(x) The state board of technical registration.

(y) The Arizona state veterinary medical examining board.

(z) The acupuncture board of examiners.

(aa) The Arizona regulatory board of physician assistants.

(bb) The board of athletic training.

(cc) The board of massage therapy.