40-22a14. Same; exceptions; review procedure; confidentiality. On and after July 1, 2011:

(a) The provisions of K.S.A. 40-22a13 through 40-22a16, and amendments thereto, shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issues as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(b) The right to external review under K.S.A. 40-22a13 through 40-22a16, and amendments thereto, shall not be construed to change the terms of coverage under a health insurance plan or insurance policy.

(c) The insurer or health insurance plan shall provide written notice to the insured of a final adverse decision and the opportunity for requesting an external review.

(d) (1) The insured has the right to request an independent external review of an adverse decision by a health insurance plan or insurer when:

(A) The insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has an emergency medical condition, in which case an expedited procedure is used; or

(B) the insured has not received a final decision from the insurer within 60 days of seeking the internal review, except to the extent that the delay was requested by the insured.

(2) Whenever an insurer or health insurance plan fails to strictly adhere to all appeal procedure requirements as prescribed by state or federal law, the claimant shall be deemed to have exhausted the internal claims and appeal process regardless of whether such insurer or health insurance plan asserts that:

(A) It has substantially complied with such appeal procedure; or

(B) any error it committed was de minimis.

(e) Within 120 days of receipt of an adverse decision by a health insurance plan or an insurer, any request for external review shall be made in writing to the commissioner from the following persons: (1) The insured; (2) the treating physician or health care provider acting on behalf of the insured with written authorization from the insured; or (3) a legally authorized designee of the insured.

(f) The insured shall provide all information in the possession of the insured pertaining to the adverse decision in order for the commissioner to make a preliminary determination for an external review. The insured also shall provide the commissioner with an appeal form, and a fully executed release for the commissioner and the external review organization to obtain any necessary medical records from the insurer or health insurance plan and any other relevant provider.

(g) In responding to the commissioner, the insurer or health insurance plan shall provide a copy of the adverse decision given to the insured and all medical and other records pertaining to the insured's claim within five business days of the request of the commissioner.

(h) The confidentiality of any medical information submitted by the insured, on behalf of the insured, insurer or health insurance plan, shall be maintained pursuant to applicable state and federal laws.

History: L. 1999, ch. 162, § 7; L. 2011, ch. 111, § 3; July 1.