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## SENATE BILL NO. 529

Senate Amendments in [ ] — February 15, 2000

A *BILL to amend and reenact §§ 32.1-137.7 and 32.1-138.6 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2407.1, relating to certain health professional credentials.*

Patrons—Williams, Couric, Edwards, Hanger, Hawkins, Houck, Lambert, Lucas, Mims, Newman, Puckett, Puller, Quayle, Saslaw and Schrock; Delegates: Albo, Amundson, Baskerville, Brink, Bryant, Byron, Davis, Hamilton, Hargrove, Hull, Jones, S.C., Keister, Landes, Larrabee, Morgan, Purkey, Rhodes, Shuler and Woodrum

Referred to Committee on Education and Health

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 32.1-137.7 and 32.1-138.6 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 54.1-2407.1 as follows:**

§ 32.1-137.7. Definitions.

As used in this article:

"Adverse decision" means a utilization review determination by the utilization review entity that a health service rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health service or health services. When the policy, contract, plan, certificate, or evidence of coverage includes coverage for prescription drugs and the health service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse decision shall be made within twenty-four hours of the request for coverage.

"Commission" means the Virginia State Corporation Commission.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Final adverse decision" means a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision, and upon which a provider or patient may base an appeal.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in [ a state of the United States ~~the Commonwealth of Virginia~~ a state of the United States ] and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or

2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Treating health care provider" or "provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the

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SB529E

60 reasonableness and necessity of services for the treatment and care of an injury suffered by an insured  
61 for which reimbursement is claimed under a contract of insurance covering any classes of insurance  
62 defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and  
63 38.2-134.

64 "Utilization review entity" or "entity" means a person or entity performing utilization review.

65 "Utilization review plan" or "plan" means a written procedure for performing review.

66 § 32.1-138.6. Definitions.

67 In this chapter the following terms have the meanings indicated:

68 "Certificate of registration" means a certificate of registration granted by the Department of Health to  
69 a private review agent.

70 "Physician advisor" means a physician licensed to practice medicine [ *in this Commonwealth* ] who  
71 provides medical advice or information to a private review agent or a utilization review entity in  
72 connection with its utilization review activities.

73 "Private review agent" means a person or entity performing utilization reviews, except that the term  
74 shall not include the following entities or employees of any such entity so long as they conduct  
75 utilization reviews solely for subscribers, policyholders, members or enrollees:

76 1. A health maintenance organization authorized to transact business in Virginia; or

77 2. A health insurer, hospital service corporation, health services plan or preferred provider  
78 organization authorized to offer health benefits in this Commonwealth.

79 "Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of  
80 hospital, medical or other health care resources rendered or proposed to be rendered to a patient or  
81 group of patients for the purpose of determining whether such services should be covered or provided  
82 by an insurer, health services plan, health maintenance organization, or other entity or person. For  
83 purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent  
84 and retrospective medical necessity determination, and review related to the appropriateness of the site at  
85 which services were or are to be delivered. "Utilization review" shall not include (i) any review of  
86 issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the  
87 provision of services, (ii) any review of patient information by an employee of or consultant to any  
88 licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the  
89 reasonableness and necessity of services for the treatment and care of an injury suffered by an insured  
90 for which reimbursement is claimed under a contract of insurance covering any classes of insurance  
91 defined in §§ 38.2-117, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132  
92 and 38.2-134.

93 "Utilization review program" means a program for conducting utilization reviews by a private review  
94 agent.

95 § 54.1-2407.1. Credentials required to perform certain activities.

96 A. [ ~~Any person~~ Any employee ] making a final adverse decision regarding the medical necessity or  
97 appropriateness of any diagnosis, course of treatment or care of a patient when such diagnosis, course  
98 of treatment or care has been rendered by a health professional regulated by a health regulatory board  
99 within the Department of Health Professions [ ~~(i) shall be deemed to be engaged in the practice of the~~  
100 ~~same or similar specialty as the specialty which typically manages patients for the relevant medical~~  
101 ~~condition, procedure, treatment or care, and (ii)~~ ] shall hold a valid certificate, license or registration  
102 issued by the relevant Virginia health regulatory board.

103 B. This section shall not be construed to prohibit or limit the practice of any person certified,  
104 licensed or registered to practice a health profession by a health regulatory board within the  
105 Department of Health Professions so long as such person is acting within the scope of his professional  
106 practice. [ In addition, the provisions of this section shall not be construed to apply to matters relating  
107 to workers' compensation or to decisions made by third-party administrators on workers' compensation  
108 matters. ]