VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-5902 and 38.2-5905 of the Code of Virginia, relating to expedited appeals of final adverse decisions regarding health care coverage.

[H 3137]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-5902 and 38.2-5905 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-5902. Appeals; impartial health entity.

A. The Bureau of Insurance shall contract with one or more impartial health entities for the purpose of performing the review of final adverse decisions. The Commission shall adopt regulations to assure that the impartial health entity conducting the review has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person. The impartial health entity shall review the written appeal; the response of the utilization review entity; any affidavits which either the covered person, the treating health care provider, or the utilization review entity may file with the Bureau of Insurance; and such medical records as the impartial health entity shall deem appropriate. The impartial health entity shall issue its written recommendation affirming, modifying or reversing the final adverse decision within ~~thirty~~ *30* working days of the date that the impartial review entity has received from all parties all documentation and information necessary for it to complete its review. The Commissioner or his designee, based upon such recommendation, shall issue a written ruling affirming, modifying or reversing the final adverse decision within ~~ten~~ *10* working days after his receipt of the recommendation of the impartial review entity*; however, if the regular process for the issuance of such written ruling will delay the rendering of treatment for a patient whose condition would be terminal without the treatment, the Commissioner or his designee shall issue his written ruling affirming, modifying, or reversing the final adverse decision no later than one business day following the receipt of such recommendation*. Such written ruling shall not be construed as a final finding, order or judgment of the Commission, and shall be exempt from the application of the Administrative Process Act (§ 2.2-4000 et seq.). The written ruling of the Commissioner or his designee shall affirm the recommendations of the impartial health entity unless the Commissioner or his designee finds in his ruling that the impartial health entity exceeded its authority or acted arbitrarily or capriciously. The written ruling of the Commissioner or his designee shall bind the covered person and the utilization review entity to the extent to which each would have been obligated by a judgment entered in an action at law or in equity with respect to the issues which the impartial review entity may examine when reviewing a final adverse decision under this section. Failure by the utilization review entity to comply with the written ruling of the Commissioner or his designee within ~~thirty~~ *30* days of the date of such ruling*, or within three business days following receipt by the utilization review entity of an expedited ruling* shall be deemed a knowing and willful violation of this section. The impartial health entity shall not be affiliated or a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

B. The Bureau of Insurance shall contract with one or more impartial health entities such as medical peer review organizations and independent utilization review companies which the Bureau of Insurance shall determine to possess the necessary credentials and otherwise be qualified to perform such review. Prior to assigning an appeal to an impartial health entity, the Bureau of Insurance shall verify that the impartial health entity conducting the review of a final adverse decision has no relationship or association with (i) the utilization review entity, or any officer, director or manager of such utilization review entity, (ii) the covered person, (iii) the treating health care provider, or any of its employees or affiliates, (iv) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (v) the development or manufacture of the drug, device, procedure or other therapy which is the subject of the final adverse decision. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

C. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

D. Any utilization review entity that is required to provide previously denied services as a result of

the review by the impartial health entity shall be subject to payment of such fees as the Commissioner, in his sole discretion, shall deem appropriate to cover the costs of the review. All such fees shall be collected by the Bureau of Insurance and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. Failure by the utilization review entity to remit such fee within thirty days of the date notice of such fee is mailed to the utilization review entity shall be deemed a knowing and willful violation of this section.

§ 38.2-5905. Regulations.

The Commission shall promulgate regulations effectuating the purpose of this chapter. Such regulations shall include (i) provisions for expedited consideration of appeals in cases involving emergency health care *or care for a terminal condition* and (ii) standards, credentials and qualifications for impartial health entities.