CHAPTER 395

An Act to amend and reenact §§ 32.1-137.13, 32.1-137.14, and 32.1-137.15 of the Code of Virginia, relating to health care services; utilization review.

[H 11]

Approved April 11, 2010

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.13, 32.1-137.14, and 32.1-137.15 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-137.13. Adverse decision.

A. The treating provider shall be notified in writing of any adverse decision within two working days of the decision; however, the treating provider shall be notified orally by telephone within ~~twenty-four~~ *24* hours of any adverse decision for a prescription known to be for the alleviation of cancer pain. Any such notification shall include instructions for the provider on behalf of the covered person to *(i)* seek a reconsideration of the adverse decision *pursuant to § 32.1-137.14*, including the contact name, address, and telephone number of the person responsible for making the adverse decision, *and (ii) seek an appeal of the adverse decision pursuant to § 32.1-137.15, including the contact name, address, and telephone number to file and perfect such appeal*.

B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity. For any adverse decision relating to a prescription to alleviate cancer pain, a physician advisor shall review the issue of medical necessity with the provider.

§ 32.1-137.14. Reconsideration of adverse decision.

A. *A treating provider may request reconsideration of an adverse decision pursuant to this section or may appeal an adverse decision pursuant to § 32.1-137.15.* Any reconsideration of an adverse decision shall *only* be requested by the *treating* provider on behalf of the covered person. A decision on reconsideration shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel.

B. The treating provider on behalf of the covered person shall be *(i)* notified *verbally at the time* of the determination of the reconsideration of the adverse decision *and in writing following the determination of the reconsideration of the adverse decision*, in accordance with § 32.1-137.9, including the criteria used and the clinical reason for the adverse decision~~,~~ *and* the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and ~~the opportunity for~~ *(ii) notified verbally at the time of the determination of the reconsideration of the adverse decision of the process for* an appeal *of the determination* pursuant to § 32.1-137.15 *and the contact name, address, and telephone number to file and perfect an appeal. If the treating provider on behalf of the covered person requests that the adverse decision be reviewed by a peer of the treating provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal pursuant to § 32.1-137.15. In such cases, the covered person shall be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during the reconsideration process pursuant to this section shall be converted to the appeal process, and no additional actions shall be required of the treating provider to perfect the appeal.*

~~B~~ *C.* Any reconsideration shall be rendered and the decision provided to the treating provider and the covered person in writing within ~~ten~~ *10* working days of receipt of the request for reconsideration.

§ 32.1-137.15. Final adverse decision; appeal.

A. Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than ~~sixty~~ *60* working days after receiving the required documentation. The decision shall be in writing and shall state the criteria used and the clinical reason for the decision. If the appeal is denied, such notification shall include a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2, the procedures for making such an appeal, and the binding nature and effect of such an appeal, including all forms prescribed by the Bureau of Insurance pursuant to § 38.2-5901. Such notification shall also include the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman. Further, such notification shall

advise any such covered person that, except in the instance of fraud, any such appeal herein may preclude such person's exercise of any other right or remedy relating to such adverse decision. An expedited appeals process of no more than ~~twenty-four~~ *24* hours shall be established and conducted by telephone to consider any final adverse decision that relates to a prescription to alleviate cancer pain.

B. Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal shall be a peer of the treating health care provider, shall be board certified ~~or board eligible~~ *in the same or similar specialty as the treating health care provider*, and shall be specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal shall (i) not have participated in the adverse decision or any prior reconsideration thereof; (ii) not be employed by or a director of the utilization review entity; and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

C. The utilization review entity shall provide an opportunity for the appellant to present additional evidence for consideration on appeal. Before rendering an adverse appeal decision, the utilization review entity shall review the pertinent medical records of the covered person's provider and the pertinent records of any facility in which health care is provided to the covered person which have been furnished to the entity.

D. In the appeals process, due consideration shall be given to the availability or nonavailability of alternative health care services proposed by the entity. No provision herein shall prevent an entity from considering any hardship imposed by the alternative health care on the patient and his immediate family.

E. When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis. The treating health care provider shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration relating to a prescription to alleviate cancer pain.

The decision on an expedited appeal shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor on the panel.

The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information.

An expedited appeal may be requested only when the regular reconsideration and appeals process will delay the rendering of health care in a manner that would be detrimental to the health of the patient or would subject the cancer patient to pain. Both providers and utilization review entities shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner.

An expedited appeal decision may be further appealed through the standard appeal process established by the entity unless all material information and documentation were reasonably available to the provider and to the entity at the time of the expedited appeal, and the physician advisor reviewing the case under expedited appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

F. The appeals process required by this section does not apply to any adverse decision, reconsideration, or final adverse decision rendered solely on the basis that a health benefit plan does not provide benefits for the health care rendered or requested to be rendered.

G. No entity performing utilization review pursuant to this article or Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of this title, shall terminate the employment or other contractual relationship or otherwise penalize a health care provider for advocating the interest of his patient or patients in the appeals process or invoking the appeals process, unless the provider engages in a pattern of filing appeals that are without merit.

2. That the provisions of this act shall become effective on October 1, 2010.