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HOUSE BILL NO. 11

Offered January 13, 2010

Prefiled December 7, 2009

A BILL to amend and reenact §§ 32.1-137.7 and 32.1-137.14 of the Code of Virginia, relating to health services; utilization review.

Patrons—Marshall, R.G., O'Bannon and Peace

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.7 and 32.1-137.14 of the Code of Virginia are amended and reenacted 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~~ *24* 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.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review organization responsible for compliance with the provisions of this article.

"Peer of the treating health care provider" means a physician ~~or other health care professional~~ who holds a nonrestricted license *to practice medicine* in the Commonwealth ~~of Virginia~~ or under a comparable licensing law of a state of the United States and ~~in~~ *who maintains* the same or similar *scope of practice or* specialty *or subspecialty, as defined by the American Board of Medical Specialties, as the treating health care provider. If the treating health care provider is not a physician licensed to practice medicine in the Commonwealth, "peer of the treating health care provider" includes another health care professional who holds a nonrestricted license in the Commonwealth or under a comparable licensing law of a state of the United States 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 in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States 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 reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and 38.2-134.

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

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

§ 32.1-137.14. Reconsideration of adverse decision.

A. Any reconsideration of an adverse decision shall be requested by the 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~~.

The treating provider on behalf of the covered person shall be notified of 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, 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 an appeal pursuant to § 32.1-137.15.

B. 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.