12100674D

HOUSE BILL NO. 398

Offered January 11, 2012
Prefiled January 10, 2012

A BILL to amend and reenact §§ 32.1-137.10 and 54.1-2903 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.10:1, relating to diagnostic radiology testing; authorization decisions.

Patron—Hope

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.10 and 54.1-2903 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.10:1 as follows:

§ 32.1-137.10. Utilization review plan required.

A. Each utilization review entity subject to this article shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of § 32.1-137.9 and other applicable provisions of this article. Such plan shall contain, at a minimum, the following:

1. Specific procedures to be used in review determinations, including an expedited review of no more than twenty-four hours for review determinations relating to prescriptions for the alleviation of cancer pain;

2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment;

3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan;

4. A provision for a process for reconsideration of adverse decisions in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15; ~~and~~

5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of § 32.1-137.12*; and*

6. A provision designed to ensure that adverse determinations by a radiology benefits manager are made by a licensed physician in accordance with § 38.2-3407.10:1.

B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request.

C. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A.

§ 38.2-3407.10:1. Adverse decisions by radiology benefits managers.

A. As used in this section, unless the context requires a different meaning:

"Adverse decision" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service, based upon the information provided, (i) is not a covered benefit or (ii) does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Diagnostic radiology testing" includes the following diagnostic tests: X-ray, computerized tomography, magnetic resonance imaging, positron emission tomography, fluoroscopy, ultrasound, and nuclear imaging studies, including cardiac nuclear imaging.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Radiology benefits manager" means a person, and any wholly or partially owned subsidiary of such entity, that administers diagnostic radiology and imaging benefits in any health benefit plan that

provides coverage for diagnostic radiology testing.

"Treating physician" means a physician licensed under Title 54.1 who orders or recommends to a patient a diagnostic radiology test that is based upon an in-person medical examination of the patient for whom the test is ordered or recommended.

B. If a health benefit plan provides coverage for diagnostic radiology testing and if a treating physician presents an order or recommendation for a diagnostic radiology test to a radiology benefits manager for authorization, an adverse decision that results in a denial of authorization of the treating physician's order or recommendation shall only be made by a physician licensed in the Commonwealth and subject to the regulation of the Board of Medicine. Along with any adverse decision to deny an authorization for diagnostic radiology testing, the treating physician and the patient shall be furnished with the full name, mailing address, telephone number, and employer of the radiology benefits manager physician who is making the adverse decision. In every case in which authorization to perform a diagnostic radiology test is given by a health carrier or by a radiology benefits manager that provides utilization review services for the health carrier under contract, such authorization shall be conclusive to satisfy any requirement of medical necessity in a health benefit plan or a health carrier's plan, policy, or schedule of benefits, and the provider's subsequently filed claim for payment for such services shall not be denied but shall be timely paid as provided in § 38.2-3407.15, unless there was fraud on the part of the provider in procuring the authorization.

§ 54.1-2903. What constitutes practice.

A. Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease. No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

B. Signing a birth or death certificate, or signing any statement certifying that the person so signing has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is practicing the healing arts within the meaning of this chapter except where persons other than physicians are required to sign birth certificates.

C. Any person who countermands the treatment order or recommendation of a treating physician for a diagnostic radiology test by any means or manner that is intended to influence the patient to refuse a recommended diagnostic radiology test or to elect to receive a different service than the diagnostic radiology test ordered or recommended by the treating physician shall be deemed to be practicing medicine in the Commonwealth.