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HOUSE BILL NO. 1915

Offered January 9, 2019

Prefiled January 4, 2019

A BILL to amend and reenact §§ 38.2-3561 and 38.2-3562 of the Code of Virginia, relating to health carriers; expedited reviews of adverse coverage determinations; exhaustion of internal reviews; cancer patients.

Patron—Yancey

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3561 and 38.2-3562 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3561. Standard external review.

A. Within 120 days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission. Within one business day after the date of receipt of a request for external review, the Commission shall send a copy of the request to the health carrier.

B. Within five business days following the date of receipt of the external review request from the Commission, the health carrier shall complete a preliminary review of the request to determine whether:

1. The individual is or was a covered person at the time the health care service was requested or, in the case of a retrospective review, was a covered person at the time the health care service was provided;

2. The health care service is a covered service, except as excluded for not meeting the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

3. The covered person has exhausted or is deemed to have exhausted the health carrier's internal appeal process*, provided that a covered person's exhaustion of the health carrier's internal appeal process shall not be required if the adverse determination relates to the treatment of a cancer of the covered person*; and

4. All the information and forms required to process the external review are complete.

C. Within one business day after completion of the preliminary review, the health carrier shall notify in writing the Commission, the covered person, and his authorized representative, if any, whether the request is complete and eligible for external review and, if ineligible, the reasons for ineligibility. If the request is not complete, the notice shall include what information or materials are needed to make the request complete. Such notice shall include a statement informing the covered person and his authorized representative, if any, that the health carrier's determination of ineligibility may be appealed to the Commission. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. In making this determination, the Commission's decision shall be made in accordance with the terms of the covered person's health benefit plan and the requirements of subsection B.

D. Within one business day after the date of receipt of the notice described in subsection C, the Commission shall assign an independent review organization to conduct the external review and notify in writing the health carrier, the covered person, and his authorized representative, if any, of the request's eligibility and acceptance for external review and the name of the assigned independent review organization. The Commission shall include in such notice a statement that the covered person or his authorized representative may submit in writing to the assigned independent review organization, within five business days following the date of receipt, additional information that the independent review organization shall consider when conducting the external review.

E. Within five business days after the date of receipt of the notice from the Commission, the health carrier or its designee utilization review entity shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination. Failure by the health carrier or its utilization review entity to provide the documents and information within the time specified shall not delay the conduct of the external review. If the health carrier or its utilization review entity fails to provide the documents and information within the time specified, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Within one business day after making such decision, the independent review organization shall notify the covered person, his authorized representative, if any, the health carrier, and the Commission.

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F. The assigned independent review organization shall review all of the information and documents timely received from the health carrier and any other information submitted in writing by the covered person or his authorized representative. The independent review organization is not required to, but may, accept and consider information submitted late from the covered person or his authorized representative, if any. Upon receipt of any information submitted by the covered person or his authorized representative, the assigned independent review organization shall within one business day forward the information to the health carrier.

G. Upon receipt of the information from the assigned independent review organization, the health carrier may reconsider its adverse determination or final adverse determination. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The external review may only be terminated if the health carrier decides to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service. Within one business day after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, his authorized representative, if any, the assigned independent review organization, and the Commission in writing of its decision. Upon receipt of the notice of the health carrier's decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

H. The assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider the following in reaching a decision:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan;

5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review entity; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering the information or documents described in subdivisions 1 through 6 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process or the internal appeal process.

I. Within 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person, his authorized representative, if any, the health carrier, and the Commission. The independent review organization shall include in such notice: a general description of the reason for the request for external review; the date the independent review organization received the assignment from the Commission to conduct the external review; the date the external review was conducted; the date of its decision; the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision; the rationale for its decision; and references to the evidence or documentation, including evidence-based standards, considered in reaching its decision.

J. Upon receipt of a notice reversing the adverse determination or final adverse determination, the health carrier promptly shall approve the coverage.

§ 38.2-3562. Expedited external review.

A. A covered person or his authorized representative may make a request for an expedited external review with the Commission at the time the covered person receives:

1. An adverse determination if the adverse determination involves *(i) cancer or (ii)* a medical condition of the covered person for which the time frame for completion of an expedited internal appeal involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person or his authorized representative has filed a request for an expedited internal appeal of the adverse determination; or

2. A final adverse determination if the covered person has *(i) cancer or (ii)* a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum

function, or if the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. Upon receipt of a request for an expedited external review, the Commission shall promptly send a copy of the request to the health carrier. Promptly upon receipt of such request, the health carrier shall determine whether the request meets the eligibility requirements in subsection B of § 38.2-3561. The health carrier shall promptly notify the Commission, the covered person, and his authorized representative, if any, of its eligibility determination. Such notice shall include a statement informing the covered person and his authorized representative, if any, that the health carrier's determination of ineligibility may be appealed to the Commission. If the health carrier makes an ineligibility determination, the Commission may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Commission decision shall be made in accordance with the terms of the covered person's health benefit plan and the requirements of subsection B of § 38.2-3561.

Upon receipt of the notice that the request meets the eligibility requirements, the Commission shall promptly assign an independent review organization to conduct the expedited external review. The Commission shall promptly notify the health carrier of the name of the assigned independent review organization.

C. Promptly upon receipt of the notice from the Commission of the name of the independent review organization assigned, the health carrier or its designee utilization review entity shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically, by telephone, facsimile, or any other available expeditious method.

D. The assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider the following in reaching a decision:

1. The covered person's pertinent medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan;

5. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review entity in making adverse determinations; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering the information and documents described in clauses 1 through 6 to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or internal appeal process.

E. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of an eligible request for an expedited external review, the assigned independent review organization shall make a decision to uphold or reverse the adverse determination or final adverse determination and notify the covered person, his authorized representative, if any, the health carrier, and the Commission. If such decision was not in writing, within 48 hours after the date of providing such decision, the assigned independent review organization shall provide written confirmation of the decision to the covered person, his authorized representative, if any, the health carrier, and the Commission and include the information set forth in subsection I of § 38.2-3561.

F. Upon receipt of a decision reversing the adverse determination or final adverse determination, the health carrier shall promptly approve the coverage.

G. An expedited external review shall not be available for retrospective adverse determinations or retrospective final adverse determinations.