LD1584484

HOUSE BILL NO. 1973

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Corporations, Insurance and Banking on February 2, 1995)

(Patron Prior to Substitute—Delegate Watkins)

A BILL to amend and reenact § 38.2-5300 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 54, consisting of sections numbered 38.2-5400 through 38.2-5409, relating to accident and sickness insurance; utilization review.

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-5300 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 54, consisting of sections numbered 38.2-5400 through 38.2-5409, as follows:

§ 38.2-5300. Definitions.

In this chapter *and Chapter 54 (§ 38.2-5400, et seq.) of this title*, the following ~~words~~ *terms* have the meanings indicated:

"Certificate" means a certificate of registration granted by the Commission to a private review agent.

"Commission" means the State Corporation Commission.

"Physician advisor" means a physician licensed to practice medicine 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 review, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization review 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 ~~state~~*Commonwealth*.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources ~~given~~ *rendered* or proposed to be ~~given~~ *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, health maintenance organization, or other entity or person. For purposes of this chapter *and Chapter 54 (§ 38.2-5400 et seq.) of this title*, "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 review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services or any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital.

"Utilization review program" means a program for conducting utilization review by a private review agent.

CHAPTER 54.

UTILIZATION REVIEW STANDARDS AND APPEALS.

§ 38.2-5400. Definitions.

As used in this chapter:

"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.

"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 health maintenance organization, insurer, health services plan, or preferred provider organization.

"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.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

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

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

§ 38.2-5401. Application to and compliance by utilization review entities.

A. No utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this chapter.

B. This chapter shall not apply to utilization review performed under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974.

C. This chapter shall not apply to private review agents subject to Chapter 53 (§ 38.2-5300 et seq.) of this title.

§ 38.2-5402. Requirements and standards for utilization review entities.

A. Each entity shall establish standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases. The entity shall make available to any provider, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws.

B. An adverse decision shall be made only in accordance with § 38.2-5406.

C. Each entity shall have a process for reconsideration of an adverse decision in accordance with § 38.2-5407 and an appeals process in accordance with § 38.2-5408.

D. Each entity shall make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.

E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations.

F. Each entity shall notify its covered persons of the review process, and shall so notify the covered person's provider upon written request by the provider.

G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review.

H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with § 38.2-5404.

I. The Commission shall have the right to determine that an entity has complied with the requirement that the entity establish requirements and standards pursuant to this section; however, the Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5403. Utilization review plan required.

A. Each utilization review entity subject to this chapter shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of § 38.2-5402 and other applicable provisions of this chapter. Such plan shall contain at a minimum the following:

1. Specific procedures to be used in review determinations;

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 § 38.2-5407, and an appeals process in accordance with § 38.2-5408; and

5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with § 38.2-5405 C.

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 Commission 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; however, the Commission shall have no jurisdiction to determine the propriety of such plan.

§ 38.2-5404. Accessibility of utilization review entity.

A. A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern time zone shall provide covered persons advance written notification of the eastern time zone hours during which those entities are accessible; provided that such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour

information for incoming calls outside of normal business hours.

B. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5405. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information.

A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later.

B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate.

C. Each entity shall have reasonable access to patient-specific medical records and information.

D. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5406. Adverse decision.

A. The treating provider shall be notified of any adverse decision within two working days of the decision. Any such notification shall include instructions for the provider to seek a reconsideration of the adverse decision, including a contact name, address, and telephone number.

B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. In any instance in which certification is questioned on the basis of medical necessity, 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.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5407. Reconsideration of adverse decision.

A. Any reconsideration of an adverse decision 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 shall be notified of the determination of the reconsideration of the adverse decision, in accordance with § 38.2-5402, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting(s), if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to § 38.2-5408.

B. Any reconsideration shall be rendered and the decision provided to the treating provider within ten working days of receipt of the request for reconsideration.

C. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5408. 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 working days after receiving the required documentation. The decision shall be in writing if so requested and shall state the criteria used and the clinical reason for the decision.

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 must be a peer of the treating health care provider, must be board certified or board eligible, and must 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 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.

1. 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.

2. 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 cause a delay in the rendering of health care that would be detrimental to the health of the patient. 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 or insurer, health services plan, health maintenance organization or preferred provider organization performing utilization review pursuant to this chapter or Chapter 53 (§ 38.2-5300 et seq.) 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.

H. The Commission shall have no jurisdiction to adjudicate controversies arising out of this section.

§ 38.2-5409. Records.

Every entity subject to this chapter shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Commission, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; review complaints received, including the manner in which the complaints were resolved; the number and type of adverse decisions, and reconsiderations; the number and outcome of final adverse decisions and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records shall be maintained or caused to be maintained by the utilization review entity for a period of five years, and all such records shall be subject to examination by the Commission.