

VIRGINIA ACTS OF ASSEMBLY -- 1999 SESSION

CHAPTER 857

An Act to amend and reenact §§ 32.1-137.7, 32.1-137.10, 32.1-137.13, 32.1-137.15, 38.2-4214, and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.6:1, relating to utilization review and coverage for cancer pain medications.

[S 1300]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.7, 32.1-137.10, 32.1-137.13, 32.1-137.15, 38.2-4214, and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.6:1 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 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.

"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.

"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 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.

§ 32.1-137.10. 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.

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.

§ 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 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 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. 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*.

§ 32.1-137.15. 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 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. *An expedited appeals process of no more than twenty-four 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, 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 Chapter 53 (§ 38.2-5300 et seq.) of Title 38.2, 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.

§ 38.2-3407.6:1. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, an outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits shall not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

B. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

C. The provisions of this section are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through ~~38.2-3407.6~~ 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3514.2, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, §§ ~~38.2-3525~~, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3543.2, 38.2-3600 through 38.2-3607, Chapter 53 (§ 38.2-5300 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) ~~of this title~~, §§ 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through ~~38.2-3407.6~~ 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.7, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2,

38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.