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SENATE BILL NO. 1235

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on February 8, 1999)

(Patron Prior to Substitute—Senator Williams)

A BILL to amend and reenact §§ 32.1-137.6, 32.1-137.15 and 38.2-5804 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5904, relating to review of adverse utilization review decisions; review of claims appeal by an independent external panel.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.6, 32.1-137.15 and 38.2-5804 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 59, consisting of sections numbered 38.2-5900 through 38.2-5904 as follows:

§ 32.1-137.6. Complaint system.

A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and maintain for each of its managed care health insurance plans a complaint system approved by the Commissioner and the Bureau of Insurance to provide reasonable procedures for the resolution of written complaints in accordance with the requirements established under this article and Title 38.2, and shall include the following:

1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review by the Commissioner.

2. Each managed care health insurance plan licensee shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number to which complaints shall be directed and shall also specify any required limits imposed by or on behalf of the managed care health insurance plan. *Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.*

B. The Commissioner, in cooperation with the Bureau of Insurance, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this article shall be assessed by the State Health Commissioner under this article. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of Title 38.2, shall be assessed by the Bureau of Insurance.

C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall submit to the Commissioner an annual complaint report in a form agreed and prescribed by the Board and the Bureau of Insurance. The complaint report shall include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the managed care health insurance plan's health care providers.

The Department of Personnel and Training and the Department of Medical Assistance Services shall file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing appropriate information on all complaints received concerning quality of care and utilization review under their respective health benefits program and managed care health insurance plan licensee contractors.

D. The Commissioner shall examine the complaint system under subsection B for compliance of the complaint system with respect to quality of care and shall require corrections or modifications as deemed necessary.

§ 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. *If the appeal is denied, such notification shall include a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance in accordance with Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2, the procedures for making such an appeal, and the*

binding nature and effect of such an appeal, including all forms prescribed by the Bureau of Insurance pursuant to § 38.2-5901.

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 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. 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~~ *Article 2.1 of Chapter 5 (§ 32.1-138.6 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.

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number *of the managed care licensee* to which complaints shall be directed and shall also specify any required limits imposed by or on behalf of the MCHIP. *Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.*

B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this chapter shall be assessed by the State Health Commissioner

pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Commission and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers.

D. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.

CHAPTER 59.

INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS.

§ 38.2-5900. Application of chapter; definitions.

This chapter shall apply to all utilization review entities established pursuant to Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when used in this chapter.

§ 38.2-5901. Review by the Bureau of Insurance.

A. A covered person or a treating health care provider, with the consent of the covered person, may in accordance with this section appeal to the Bureau of Insurance for review of any final adverse decision concerning a health service costing more than $500, determined in accordance with regulations adopted by the Commission. The appeal shall be filed within thirty days of the final adverse decision, shall be in writing on forms prescribed by the Bureau of Insurance, shall include a general release executed by the covered person for all medical records pertinent to the appeal, and shall be accompanied by a fifty-dollar nonrefundable filing fee. The fee shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Commission may, for good cause shown, waive the filing fee upon a finding that payment of the filing fee will cause undue financial hardship for the covered person. The Commission shall provide a copy of the written appeal to the utilization review entity which made the final adverse decision.

B. The Bureau of Insurance or its designee shall conduct a preliminary review of the appeal to determine (i) whether the applicant is a covered person or a treating health care provider with the consent of the covered person, (ii) whether the benefit or service that is the subject of the application reasonably appears to be a covered service costing more than $500, (iii) whether all complaint and appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 have been exhausted, and (iv) whether the application is otherwise complete and filed in compliance with this section. Such preliminary review shall be conducted within fifteen days of receipt of all information and documentation necessary to conduct a preliminary review. The Bureau of Insurance shall not accept for review any application which fails to meet the criteria set forth in this subsection. Within five working days of completion of the preliminary review, the Bureau of Insurance or its designee shall notify the applicant and the utilization review entity in writing whether the appeal has been accepted for review, and if not accepted, the reasons therefor.

C. The covered person, the treating health care provider, and the utilization review entity shall provide copies of the medical records relevant to the final adverse decision to the Bureau of Insurance within ten working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal. The confidentiality of such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. The Bureau of Insurance or its designee may, if deemed necessary, request additional medical records from the covered person, any treating health care provider or the utilization review entity. Failure to comply with such request within twenty working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision in the discretion of the Commission.

§ 38.2-5902. Appeals; impartial health entity.

A. The Bureau of Insurance shall contract with one or more impartial health entities for the purpose of performing the review of final adverse decisions. The Commission shall adopt regulations to assure that the impartial health entity conducting the review has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of

health care, and appropriate in light of the contractual obligations of the utilization review entity. The impartial health entity shall review the written appeal; the response of the utilization review entity; any affidavits which either the covered person, the treating health care provider, or the utilization review entity may file with the Bureau of Insurance; and such medical records as the impartial health entity shall deem appropriate. The impartial health entity shall issue its written recommendation affirming, modifying or reversing the final adverse decision within sixty days of the acceptance of the appeal by the Bureau of Insurance. The Commission, based upon such recommendation, shall issue a written order affirming, modifying or reversing the final adverse decision. The Commission's order shall carry out the recommendations of the impartial health entity unless the impartial health entity exceeded its authority, acted arbitrarily or capriciously, or abused its discretion.

B. The Commission shall contract with one or more impartial health entities such as medical peer review organizations, independent utilization review companies, or other health care entities which the Commission shall determine to possess the necessary credentials and otherwise to be qualified to perform such review. Prior to assigning an appeal to an impartial health entity, the Commission shall verify that the impartial health entity conducting the review of a final adverse decision has no relationship or association with (i) the utilization review entity, or any officer, director or manager of such utilization review entity, (ii) the covered person, (iii) the treating health care provider, or any of its employees or affiliates, (iv) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (v) the development or manufacture of the drug, device, procedure or other therapy which is the subject of the final adverse decision.

C. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of their powers and duties.

D. Any managed care health insurance plan licensee that is required to provide previously denied services as a result of the review by the impartial health entity shall be subject to payment of such fees as the Commission shall deem appropriate to cover the costs of the review.

§ 38.2-5903. Assessment to fund appeals.

A. Each licensed insurer, health maintenance organization, and health services plan doing business in the Commonwealth by writing any type of insurance as defined in § 38.2-109 shall pay, in addition to any other assessments provided in this title, an assessment in an amount not to exceed 0.01 percent of the direct gross premium income during the preceding calendar year. Such assessment shall be based upon the anticipated costs attributable to implementation of the review of final adverse decisions by the Bureau of Insurance pursuant to this chapter, adjusted for actual receipts and expenditures in the prior fiscal year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403.

B. The assessment shall be collected by the Commission and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400.

§ 38.2-5904. Rules and regulations.

The Commission shall promulgate regulations effectuating the purpose or this chapter. Such regulations shall include (i) provisions for expedited consideration of appeals in cases involving emergency health care and (ii) standards, credentials and qualifications for impartial health entities.

2. That the Commission shall promulgate the first set of regulations to implement the provisions of this act to be effective within 280 days of the enactment of this provision.

3. This act shall take effect on July 1, 1999; however, the appeal processes set forth in this act shall not take effect until the earlier of (i) ninety days following the promulgation of regulations by the Commission as set forth in § 38.2-5904 or (ii) July 1, 2000.