VIRGINIA ACTS OF ASSEMBLY -- 1998 SESSION

CHAPTER 129

An Act to amend and reenact §§ 38.2-5400 and 38.2-5401 of the Code of Virginia, to amend the Code of Virginia by adding in Chapter 5 of Title 32.1 an article numbered 2.1, consisting of sections numbered 32.1-138.6 through 32.1-138.15, and to repeal Chapter 53 (§§ 38.2-5300 through 38.2-5309) of Title 38.2 of the Code of Virginia, relating to insurance; private review agents.

[S 224]

Approved March 13, 1998

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-5400 and 38.2-5401 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 5 of Title 32.1 an article numbered 2.1, consisting of sections numbered 32.1-138.6 through 32.1-138.15, as follows:

Article 2.1.

Private Review Agents.

§ 32.1-138.6. Definitions.

In this chapter the following terms have the meanings indicated:

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

"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.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources 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, health maintenance organization, 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, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132 and 38.2-134.

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

§ 32.1-138.7. Certificates of registration required; issuance; transferability; regulations.

A private review agent may not conduct utilization reviews in the Commonwealth unless the Department has granted the private review agent a certificate of registration. The Department shall issue a certificate of registration to an applicant that has met the minimum standards required by this article and applicable regulations of the Department. A certificate of registration issued under this article is not transferable.

§ 32.1-138.8. Consultation with health regulatory boards.

If in the administration of this article a question concerning compliance with standards of practice governing any health care profession arises pursuant to Subtitle III (54.1-2400 et seq.) of Title 54.1, the Commissioner or his designee shall consult with the appropriate health regulatory board within the Department of Health Professions.

§ 32.1-138.9. Standards for approval.

Each private review agent shall file an application with the Department which shall meet the following minimum standards and any additional standards established by regulation pursuant to § 32.1-138.15, and pay a filing fee established by the Department, in order to be approved by the Department:

1. A description of the procedures to be used in evaluating proposed or delivered hospital, medical, or other health care services;

2. The procedures by which patients or providers may seek reconsideration of determinations by private review agents;

3. The type and qualifications of the personnel either employed or under contract to perform the utilization review;

4. Procedures and policies which ensure that patient-specific medical records and information shall be kept strictly confidential except as authorized by the patient or by regulations adopted pursuant to this article; and

5. Assurances that reviewers be readily accessible by telephone to patients and providers at least forty hours per week during normal business hours.

§ 32.1-138.10. Expiration; renewal.

Each certificate of registration shall expire on the second anniversary of its effective date unless the certificate of registration is renewed for a two-year term as provided in this section. The Department shall renew the certificate of registration for an additional two-year term if the applicant is otherwise entitled to the certificate of registration, pays to the Department the renewal fee set by regulations, submits to the Department a renewal application on a form prescribed by the Department, submits satisfactory assurances of compliance with the requirements of this article and updates information on file with the Department pursuant to this section.

§ 32.1-138.11. Denial; revocation.

A. The Department may deny a certificate of registration to any applicant if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this article or by any regulations promulgated pursuant to this article.

B. The Department may revoke a certificate of registration, or place the holder on probation with terms and conditions, if the holder demonstrates that it is unable or unwilling to meet the requirements of this chapter or of regulations adopted pursuant to this article.

§ 32.1-138.12. Waiver of requirements of article.

The Department shall waive the requirements of this article for a private review agent that operates 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.

§ 32.1-138.13. Access to and confidentiality of patient-specific medical records and information.

Private review agents who have been granted a certificate of registration by the Department shall have reasonable access to patient-specific medical records and information to the extent and in the manner authorized by regulation.

§ 32.1-138.14. No private right of action created.

This article shall not be construed to create a private right of action against a private review agent on behalf of a subscriber, policyholder, member, enrollee or other person.

§ 32.1-138.15. Regulations.

The Department shall promulgate regulations, pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.), to implement the provisions of this article, which shall include, but not be limited to, the following items:

1. Minimum qualifications to perform review;

2. Procedures which require the private review agent to provide the attending physician an opportunity to consult with a physician advisor prior to issuance of a final denial in any case in which there is an initial recommendation to deny coverage;

3. Guidelines regarding access to and confidentiality of patient-specific medical records and information; and

4. Setting the amount of any fees required by this article, which shall be sufficient to pay for the administrative costs of regulation under this article.

§ 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.

"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 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.

"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 resources 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, health maintenance organization, or other entity or person. For purposes of this chapter, "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, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 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.

§ 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~~ *Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of Title 32.1.*

D. This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

2. That Chapter 53 (§§ 38.2-5300 through 38.2-5309) of Title 38.2 of the Code of Virginia is repealed.

3. That regulations promulgated by the Virginia State Corporation Commission pursuant to Chapter 53 (§§ 38.2-5300 through 38.2-5309) of Title 38.2 of the Code prior to the effective date of this act regarding private review agents shall continue in effect and shall be deemed to be the regulations of the Department of Health until the earlier of (i) the effective date of the regulations promulgated by the Department of Health pursuant to this act or (ii) January 1, 2000.

4. That all records necessary for administration of this act shall be transferred by the Virginia State Corporation Commission to the Department of Health on or before the effective date of this act.