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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2006

A N A C T

RELATING TO HEALTHCARE SERVICES - UTILIZATION REVIEW ACT

Introduced By: Representatives Costantino, Carter, and Pacheco

Date Introduced: February 16, 2006

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Sections 23-17.12-2, 23-17.12-3, 23-17.12-4, 23-17.12-5, 23-17.12-8 and 23-17.12-9 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization Review Act" are hereby amended to read as follows:

23-17.12-2. Definitions. -- As used in this chapter, the following terms are defined as follows:

(1) "Adverse determination" means ~~any~~ a utilization review decision by a review agent not to ~~certify~~ authorize a health care service. A decision by a review agent to ~~certify~~ authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse determinations include decisions not to ~~certify~~ authorize formulary and nonformulary medication.

(2) "Appeal" means a subsequent review of an adverse determination upon request by a patient or provider to reconsider all or part of the original decision.

(3) "Authorization" means the review agent's utilization review, performed according to subsection 23-17.12-2(20), concluded that the allocation of health care services of a provider, given or proposed to be given to a patient was approved or authorized.

(4) "Benefit determination" means a decision of the enrollee's entitlement to payment for covered health care services as defined in an agreement with the payor or its delegate.

~~(2)~~ (5) "Certificate" means a certificate of registration granted by the director to a review

agent.

(6) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.

(7) "Concurrent assessment" means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. This review does not mean the elective requests for clarification of coverage or claims review or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.

~~(3)~~ (8) "Department" means the department of health.

~~(4)~~ (9) "Director" means the director of the department of health.

~~(5)~~ (10) "Emergent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

~~(6)~~ (11) "Patient" means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.

(12) "Payor" means a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state.

~~(7)~~ (13) "Practitioner" means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist.

(14) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.

~~(8)~~ (15) "Provider" means any health care facility, as defined in section 23-17-2 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(16) "Retrospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.

~~(9)~~ (17) "Review agent" means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:

(i) A business entity doing business in this state;

(ii) A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, non-profit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or

(iii) A provider.

(18) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

~~(10)~~ (19) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance abuse or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in subdivision ~~(5)~~ (10).

~~(11)~~ (20) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient ~~or group of patients~~. Utilization review does not include:

(i) Elective requests for the clarification of coverage; or

(ii) Benefit determination; or

~~(ii)~~ (iii) Claims review that does not include the assessment of the medical necessity and appropriateness; or

~~(iii)~~ (iv) A provider's internal quality assurance program except if it is associated with a health care financing mechanism; or

~~(iv)~~ (v) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or

~~(v)~~ (vi) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of title 5 and practicing in a pharmacy operating as part of a ~~license~~ licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

~~(12)~~ (21) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

~~(13)~~ (22) "Health care services" means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other services, activities, or supplies that are covered by the patient's benefit plan.

~~(14)~~ (23) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

23-17.12-3. General certificate requirements. -- (a) A review agent shall not conduct utilization review in the state unless the department has granted the review agent a certificate.

(b) Individuals shall not be required to hold separate certification under this chapter when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.

(c) The department shall issue a certificate to an applicant that has met the minimum standards established by this chapter, and regulations promulgated in accordance with it, including the payment of any fees as required, and other applicable regulations of the department.

(d) A certificate issued under this chapter is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer.

(e) After consultation with the ~~payers~~ payors and providers of health care, the department shall adopt regulations necessary to implement the provisions of this chapter.

(f) The director of health is authorized to establish any fees for initial application, renewal applications, and any other administrative actions deemed necessary by the director to implement this chapter.

(g) The total cost of certification under this title shall be borne by the certified entities and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the department engaged in those certifications less any salary reimbursements and shall be paid to the director to and for the use of the department. That assessment shall be in

addition to any taxes and fees otherwise payable to the state.

(h) The application and other fees required under this chapter shall be sufficient to pay for the administrative costs of the certificate program and any other reasonable costs associated with carrying out the provisions of this chapter.

(i) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two (2) year term as provided in this chapter.

(j) Any systemic changes in the review agents operations relative to certification information on file shall be submitted to the department for approval within thirty (30) days prior to implementation.

23-17.12-4. Application process. -- (a) An applicant requesting certification or recertification shall:

(1) Submit an application provided by the director; and

(2) Pay the application fee established by the director through regulation and section 23-17.12-3(f).

(b) The application shall:

(1) Be on a form and accompanied by supporting documentation that the director requires; and

(2) Be signed and verified by the applicant.

(c) Before the certificate expires, a certificate may be renewed for an additional two (2) years.

(d) If a completed application for recertification is being processed by the department, a certificate may be continued until a renewal determination is made.

(e) In conjunction with the application, the review agent shall submit information that the director requires including:

(1) A request that the state agency regard specific portions of the standards and criteria or the entire document to constitute "trade secrets" within the meaning of that term in section 38-2-2(4)(i)(B);

(2) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(3) A copy of the materials used to inform enrollees of the requirements under the health benefit plan for seeking utilization review or pre-certification and their rights under this chapter, including information on appealing adverse determinations;

(4) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(5) A list of the third party ~~payers~~ payors and business entities for which the review agent is performing utilization review in this state and a brief description of the services it is providing for each client; and

(6) Evidence of liability insurance or of assets sufficient to cover potential liability.

(f) The information provided must demonstrate that the review agent will comply with the regulations adopted by the director under this chapter.

23-17.12-5. General application requirements. -- An application for certification or recertification shall be accompanied by documentation to evidence the following:

(a) The requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of the standards, procedures and methods to be used in evaluating proposed or delivered health care services;

(b) The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that the delegated agency is a certified utilization review agency delegated to perform utilization review pursuant to all of the requirements of this chapter;

(c) A complaint resolution process~~,~~ consistent with section ~~23-17.12-9~~ subsection 23-17.12-2(6) and acceptable to the department, whereby patients, their physicians, or other health care providers may seek ~~prompt reconsideration or appeal of adverse decisions by the review agent, as well as the~~ resolution of complaints and other matters of which the review agent has received written notice;

(d) The type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a practitioner with the same licensure status as the ordering practitioner, or a licensed physician or dentist, is permitted to make a prospective or concurrent adverse determination;

(e) The requirement that a representative of the review agent is reasonably accessible to patients, patient's family and providers at least five (5) days a week during normal business in Rhode Island and during the hours of the agency's review operations;

(f) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(g) The policies and procedures regarding the notification and conduct of patient interviews by the review agent;

(h) The requirement that no employee of, or other individual rendering an adverse determination for, a review agent may receive any financial incentives based upon the number of denials of certification made by that employee or individual;

(i) The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient ~~for whom the treating provider determines the health care service to be of an emergency nature. The emergency nature of the health care service shall be documented and signed by a licensed physician, dentist or other practitioner and may be subject to review by a review agent~~;

(j) Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based upon a reduction of services or the charges for those services, the reduction of length of stay, or utilization of alternative treatment settings; provided, nothing in this chapter shall prohibit agreements and similar arrangements; and

(k) An adverse determination and internal ~~appeal~~ appeals process ~~as required by this chapter.~~ consistent with section 23-17.12-9 and acceptable to the department, whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent.

23-17.12-8. Waiver of requirements. – (a) Except for utilization review agencies performing utilization review activities ~~performed~~ to determine the necessity and/or appropriateness of substance abuse and mental health care, treatment or services, the department shall waive all the requirements of this chapter, with the exception of those contained in sections 23-17.12-9, (a)(1)-(3), (5), (6), (8), (b)(1)-(6), and (c)(2)-(6), 23-17.12-12, and 23-17.12-14, for a review agent that has received, maintains and provides evidence to the department of accreditation from the utilization review accreditation commission (URAC) or other organization approved by the director. The waiver shall be applicable only to those services that are included under the accreditation by the utilization review accreditation commission or other approved organization.

(b) The department shall waive the requirements of this chapter only when a direct conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or the federal government or those activities under other state or federal jurisdictions.

(c) The limitation in subsection 23-17.12-8(b) notwithstanding, the department may waive or exempt all or part of the requirements of this chapter by mutual written agreement with a state department or agency when such waiver or exemption is determined to be necessary and appropriate to the administration of a health care related program. The department shall promulgate such regulations as deemed appropriate to implement this provision.

23-17.12-9. Review agency requirement for adverse determination and internal

appeals. -- (a) The ~~decision~~ adverse determination and appeals process of the review agent shall conform to the following:

(1) Notification of a prospective adverse determination by the review agent shall be mailed or otherwise communicated to the provider of record and to the patient or other appropriate individual ~~within one business day of the receipt of all information necessary to complete the review unless otherwise determined by the department in regulation for nonurgent and nonemergency services.~~ as follows:

(i) Within fifteen (15) business days of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent services;

(ii) Within seventy-two (72) hours of receipt of all the information necessary to complete a review of urgent and/or emergent services; and

(iii) Prior to the expected date of service.

(2) Notification of a concurrent adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record ~~prior to the end of the current certified~~ period as follows: ~~consistent with time frames to be established in regulations promulgated by the department.~~

(i) To the provider(s) prior to the end of the current certified period; and

(ii) To the patient within one business day of making the adverse determination.

(3) Notification of a retrospective adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record within thirty (30) business days of receipt of a request for payment with all supporting documentation for the covered benefit being reviewed.

(4) A utilization review agency shall not retrospectively deny ~~coverage~~ authorization for health care services provided to a covered person when ~~prior approval~~ an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information material to the review or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval granted by the review agent.

(5) Any notice of ~~a~~ an adverse determination ~~not to certify a health care service shall be made, documented, and signed and shall be mailed or otherwise communicated, and~~ shall include:

(i) The principal reasons for the adverse determination~~, and~~ to include explicit documentation of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in making the adverse determination. The criteria shall be in accordance with the agency criteria noted in subsection 23-17.12-9(d) and shall be made available within the first level appeal

timeframe if requested unless otherwise provided as part of the adverse determination notification process;

(ii) The procedures to initiate an appeal of the adverse determination, including ~~or~~ the name and telephone number of the person to contract with regard to an appeal~~.~~ ;

(iii) The necessary contact information to complete the two-way direct communication defined in subdivision 23-17.12-9 (a)(7); and

(iv) The information noted in subdivision 23-27.12-9(a)(5)(i)(ii)(iii) for all verbal notifications followed by written notification to the patient and provider(s).

(6) All initial retrospective adverse determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed consistent with the regulatory requirements which shall be developed by the department with the input of review agents, providers and other affected parties.

(7) ~~The requirement that, other than in exceptional circumstances, or when the patient's attending physician or dentist is not reasonably available, no~~ A level one appeal decision of an adverse determination ~~that care rendered or to be rendered is medically inappropriate~~ shall not be made until an appropriately qualified and licensed review physician, dentist or other practitioner has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician, dentist, other practitioner, other designated or qualified professional or provider responsible for treatment of the patient concerning the medical care~~.~~ , with the exception of the following:

(i) When the attending provider is not reasonably available;

(ii) When the attending provider chooses not to speak with agency staff;

(iii) When the attending provider has negotiated an agreement with the review agent for alternative care; and/or

(iv) When the attending provider requests a peer to peer communication prior to the adverse determination, the review agency shall then comply with subdivision 23-17.12-9(c)(1) in responding to such a request. Such requests shall be on the case specific basis unless otherwise arranged for in advance by the provider.

(8) All initial, prospective and concurrent adverse determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or dentist. This does not prohibit appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and treatment

options. Such a discussion shall not constitute an adverse determination provided though that any change to the provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the patient.

~~(9) The requirement that except in circumstances as may be allowed by regulations promulgated pursuant to this chapter, no adverse determination shall be made on any question relating to health care and/or medical services by any person other than an appropriately licensed physician, dentist or other practitioner.~~

~~(10)~~ (9) The requirement that, upon written request made by or on behalf of a patient, any adverse determination and/or appeal ~~that care rendered or to be rendered is medically inappropriate~~ shall include the written evaluation and findings of the reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent. ~~The verbal request must be confirmed, in writing, within seven (7) days~~.

(b) The review agent shall conform to the following for the appeal of an adverse determination:

(1) The review agent shall maintain and make available a written description of the appeal procedure by which either the patient or the provider of record may seek review of determinations not to ~~certify~~ authorize a health care service. The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than sixty (60) days.

(2) The review agent shall notify, in writing, the patient and provider of record of its decision on the appeal as soon as practical, but in no case later than fifteen (15) or twenty-one (21) ~~working~~ business days if verbal notice is given within fifteen (15) ~~working~~ business days after receiving the required documentation on the appeal.

(3) The review agent shall also provide for an expedited appeals process for emergency or life threatening situations. Each review agent shall complete the adjudication of expedited appeals within two (2) business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.

(4) All first level appeals of determinations not to authorize a health care service that had been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or a licensed dentist.

~~(4)~~(5) ~~In cases where an initial appeal to reverse an adverse determination is~~

~~unsuccessful, the review agent shall assure that~~ All second level appeal decisions shall be made, signed, and documented by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion ~~conducts the next level of review~~.

~~(5)~~(6) The review agent shall maintain records of written appeals and their resolution, and shall provide reports as requested by the department.

~~(6) All first level appeals of determinations not to certify a health care service that had been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or a licensed dentist.~~

(c) The review agency must conform to the following requirements when making its adverse determination and appeal decisions:

(1) The review agent must assure that the licensed practitioner or licensed physician is reasonably available to review the case as required under ~~subsection 23-17.12-3(c).~~ subdivision 23-17.12-9(a)(7) and shall conform to the following:

(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or patients;

(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer;

(iii) Agency peer reviewers shall respond to the provider's request for a two-way direct communication defined in subdivision 23-17.12-9(a)(7)(iv) as follows:

(a) For a prospective review of non-urgent and non-emergent health care services, a response within one (1) business day of the request for a peer discussion;

(b) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and

(c) For retrospective reviews, prior to the first level appeal decision.

(iv) The review agency will have met the requirements of a two-way direct communication, when requested and/or as required prior to the first level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly.

(v) Repeated violations of this section shall be deemed to be substantial violations pursuant to section 23-17.12-14 and shall be cause for the imposition of penalties under that section.

(2) No reviewer at any level under this section shall be compensated or paid a bonus or incentive based on making or upholding an adverse determination.

(3) No reviewer under this section who has been involved in prior reviews of the case under appeal or who has participated in the direct care of the patient may participate as the sole reviewer in reviewing a case under appeal; provided, however, that when new information has been made available at the first level of appeal, then the review may be conducted by the same reviewer who made the initial adverse determination.

(4) A review agent is only entitled to review information or data relevant to the utilization review process. A review agent may not disclose or publish individual medical records or any confidential medical information obtained in the performance of utilization review activities. A review agent shall be considered a third party health insurer for the purposes of section 5-37.3-6(b)(6) of this state and shall be required to maintain the security procedures mandated in section 5-37.3-4(c).

(5) Notwithstanding any other provision of law, the review agent, the department, and all other parties privy to information which is the subject of this chapter shall comply with all state and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (Confidentiality of Health Care Communications and Information Act) and specifically section 5-37.3-4(c), which requires limitation on the distribution of information which is the subject of this chapter on a "need to know" basis, and section 40.1-5-26.

(6) The department may, in response to a complaint that is provided in written form to the review agent, review an appeal regarding any adverse determination, and may request information of the review agent, provider or patient regarding the status, outcome or rationale regarding the decision.

(d) The requirement that each review agent shall utilize and provide upon request, ~~as determined appropriate by the director, to~~ by Rhode Island licensed hospitals and the Rhode Island Medical Society, in either electronic or paper format, written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate consultation with Rhode Island licensed physicians, hospitals, including practicing physicians, and other health care providers in the same specialty as would typically treat the services subject to the criteria as follows:

(1) Utilization review agents shall consult with no fewer than five (5) Rhode Island licensed physicians or other health care providers. Further, in instances where the screening criteria and review procedures are applicable to inpatients and/or outpatients of hospitals, the medical director of each licensed hospital in Rhode Island shall also be consulted. Utilization

review agents who utilize screening criteria and review procedures provided by another entity may satisfy the requirements of this section if the utilization review agent demonstrates to the satisfaction of the director that the entity furnishing the screening criteria and review procedures has complied with the requirements of this section.

(2) Utilization review agents seeking initial certification shall conduct the consultation for all screening and review criteria to be utilized. Utilization review agents who have been certified for one year or longer shall be required to conduct the consultation on a periodic basis for the utilization review agent's highest volume services subject to utilization review during the prior year; services subject to the highest volume of adverse determinations during the prior year; and for any additional services identified by the director.

(3) Utilization review agents shall not include in the consultations as required under paragraph (1) of this subdivision, any physicians or other health services providers who have financial relationships with the utilization review agent other than financial relationships for provisions of direct patient care to utilization review agent enrollees and reasonable compensation for consultation as required by paragraph (1) of this subdivision.

(4) All documentation regarding required consultations, including comments and/or recommendations provided by the health care providers involved in the review of the screening criteria, as well as the utilization review agent's action plan or comments on any recommendations, shall be in writing and shall be furnished to the department on request. The documentation shall also be provided on request to any licensed health care provider at a nominal cost that is sufficient to cover the utilization review agent's reasonable costs of copying and mailing.

(5) Utilization review agents may utilize non-Rhode Island licensed physicians or other health care providers to provide the consultation as required under paragraph (1) of this subdivision, when the utilization review agent can demonstrate to the satisfaction of the director that the related services are not currently provided in Rhode Island or that another substantial reason requires such approach.

(6) Utilization review agents whose annualized data reported to the department demonstrate that the utilization review agent will review fewer than five hundred (500) such requests for authorization may request a variance from the requirements of this section.

SECTION 2. This act shall take effect on January 1, 2007.

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LC02289/SUB B/2
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTHCARE SERVICES - UTILIZATION REVIEW ACT

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This act would specify various review procedures and criteria as they relate to adverse coverage discussions by a review agent regarding the administration of health care.

This act would take effect on January 1, 2007.

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