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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. 2013

A N A C T

RELATING TO HEALTH AND SAFETY -- UTILIZATION REVIEW

Introduced By: Representatives Keable, Johnston, Cimini, and Kazarian

Date Introduced: February 27, 2013

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-17.12-9 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization Review Act" is hereby amended to read as follows:

23-17.12-9. Review agency requirement for adverse determination and internal appeals. -- (a) The 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 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, exclusive of prescriptions;

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

(iii) Within forty-eight (48) hours of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent prescriptions, provided further, that the failure to comply within said forty-eight (48) hours of receipt shall result in automatic approval;

(iv) Within two (2) hours of receipt of all the information necessary to complete a review of urgent and/or emergent prescriptions; provided further, that he failure to comply within said two (2) hours of receipt shall result automatic approval;

~~(iii)~~(v) 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 period as follows:

(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 authorization for health care services provided to a covered person when 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 an adverse determination shall include:

(i) The principal reasons for the adverse determination, 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 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) A level one appeal decision of an adverse determination 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, upon written request made by or on behalf of a patient, any adverse determination and/or appeal 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.

(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 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) business days if verbal notice is given within fifteen (15) 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.

(5) All second level appeal decisions shall be made, signed, and documented by a licensed practitioner in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion.

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

(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 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 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, 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 upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HEALTH AND SAFETY -- UTILIZATION REVIEW

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This at would reduce the time required for the approval of prescription drug coverage and would provide that failure to comply within the said time would result in automatic approval of the request.

This act would take effect upon passage.

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