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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. 2015

A N A C T

RELATING TO HEALTH AND SAFETY -- HEALTH CARE SERVICES--UTILIZATION REVIEW ACT

Introduced By: Representatives McKiernan, Shekarchi, Maldonado, and Costantino

Date Introduced: February 25, 2015

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-17.12-2 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization Review Act" is hereby amended to read as follows:

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

(1) "Adverse determination" means a utilization review decision by a review agent not to authorize a health care service. A decision by a review agent to 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 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)~~ § 23-17.12-2(22), 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.

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

agent.

(6) "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols and any other criteria or rationale used by the review agent to determine the necessity and appropriateness of health care services.

~~(6)~~(7) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.

~~(7)~~(8) "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.

~~(8)~~(9) "Department" means the department of health.

~~(9)~~(10) "Director" means the director of the department of health.

~~(10)~~(11) "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.

(12) "Participating provider" means a health care provider that, under a contract with a payor or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

~~(11)~~(13) "Patient" means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.

~~(12)~~(14) "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.

~~(13)~~(15) "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)~~(16) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered, including, but not limited to, preadmission review, pretreatment review, utilization, and case management, and shall also include any insurer's or review agent's requirement that a patient or provider notify the health insurer or review agent prior to the rendering of a health care service.

~~(15)~~(17) "Provider" means any health care facility, as defined in § 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)~~(18) "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.

~~(17)~~(19) "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)~~(20) "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.

~~(19)~~(21) "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 ~~(10)~~ (11).

~~(20)~~(22) "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. Utilization review does not include:

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

(ii) Benefit determination; or

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

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

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

(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 licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

~~(21)~~(23) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

~~(22)~~(24) "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.

~~(23)~~(25) "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.

SECTION 2. Chapter 23-17.12 of the General Laws entitled "Health Care Services - Utilization Review Act" is hereby amended by adding thereto the following section:

23-17.12-9.1. Disclosure and review of prospective assessment requirements. – (a) A utilization review agent shall make any current prospective assessment requirements and restrictions, including written clinical criteria, readily accessible on its website to patients, health care providers, and the general public. Requirements shall be described in detailed, but easily understandable language.

(b) If a review agent intends either to implement a new prospective assessment

requirement or restriction, or amend an existing requirement or restriction, the review agent shall ensure that the new or amended requirement is not implemented unless the review agent's website has been updated to reflect the new or amended requirement or restriction.

(c) If a review agent intends either to implement a new prospective assessment requirement or restriction, or amend an existing requirement or restriction, the review agent shall provide contracted health care providers with written notice of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented.

(d) Review agents utilizing prospective assessment shall make statistics available regarding prospective assessment approvals and denials on their websites in a readily accessible format. Such statistics shall be divided into categories including, but not limited to:

(1) Physician specialty;

(2) Medication or diagnostic test/procedure;

(3) Indication offered; and

(4) The reason for denial.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- HEALTH CARE SERVICES--UTILIZATION REVIEW ACT

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This act would amend various provisions of the general laws to require transparency in the criteria used by utilization review agents for the prospective assessment of health care services.

This act would take effect upon passage.

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