

**Virginia Department of Health
Office of Licensure and Certification**

Extract from the Code of Virginia

**Chapter 5 of Title 32.1 of the Code of Virginia
Article 1.1
Certificate of Quality Assurance of
Managed Care Health Insurance Plan Licensees**

§ 32.1-137.1. Definitions. - As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of Insurance under Title 38.2 who is responsible for a managed

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care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society. (1998, c. 891.)

§ 32.1-137.2. Certification of quality assurance; application; issuance; denial; renewal. - A. Every managed care health insurance plan licensee shall request a certificate of quality assurance with reference to its managed care health insurance plans simultaneously with filing an initial application to the Bureau of Insurance for licensure. If already licensed by the Bureau of Insurance, every managed care health insurance plan licensee may file an application for quality assurance certification with the Department of Health by December 1, 1998, and shall file an application for quality assurance certification with the Department of Health by December 1, 1999, in order to obtain its certificate of quality assurance by July 1, 2000.

On or before July 1, 2000, the State Health Commissioner shall certify to the Bureau of Insurance that a managed care health insurance plan licensee has been issued a certificate of quality assurance by providing the Bureau of Insurance with a copy of each certificate at the time of issuance.

Application for a certificate of quality assurance shall be made on a form prescribed by the Board and shall be accompanied by a fee based upon a percentage, not to exceed one-tenth of one percent, of the proportion of direct gross premium income on business done in this Commonwealth attributable to the operation of managed care health insurance plans in the preceding biennium, sufficient to cover reasonable costs for the administration of the quality assurance program. Such fee shall not exceed \$10,000 per licensee. Whenever the account of the program shows expenses for the past biennium to be more than ten percent greater or lesser than the funds collected, the Board shall revise the fees levied by it for certification so that the fees are sufficient, but not excessive, to cover expenses; provided that such fees shall not exceed the limits set forth in this section.

All applications, including those for renewal, shall require (i) a description of the geographic area to be served, with a map clearly delineating the boundaries of the service area or areas, (ii) a description of the complaint system required under § 32.1-137.6, (iii) a description of the procedures and programs established by the licensee to assure both availability and accessibility of adequate personnel and facilities and to assess the quality of health care services provided, and (iv) a list of the licensee's managed care health insurance plans.

B. Every managed care health insurance plan licensee certified under this article shall renew its certificate of quality assurance with the Commissioner biennially by July 1, subject to payment of the fee.

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C. The Commissioner shall periodically examine or review each applicant for certificate of quality assurance or for renewal thereof.

No certificate of quality assurance may be issued or renewed unless a managed care health insurance plan licensee has filed a completed application and made payment of a fee pursuant to subsection A of this section and the Commissioner is satisfied, based upon his examination, that, to the extent appropriate for the type of managed care health insurance plan under examination, the managed care health insurance plan licensee has in place and complies with: (i) a complaint system for reasonable and adequate procedures for the timely resolution of written complaints pursuant to § 32.1-137.6; (ii) a reasonable and adequate system for assessing the satisfaction of its covered persons; (iii) a system to provide for reasonable and adequate availability of and accessibility to health care services for its covered persons; (iv) reasonable and adequate policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons; (v) reasonable and adequate standards and procedures for credentialing and recredentialing the providers with whom it contracts; (vi) reasonable and adequate procedures to inform its covered persons and providers of the managed care health insurance plan licensee's policies and procedures; (vii) reasonable and adequate systems to assess, measure, and improve the health status of covered persons, including outcome measures, (viii) reasonable and adequate policies and procedures to ensure confidentiality of medical records and patient information to permit effective and confidential patient care and quality review; (ix) reasonable, timely and adequate requirements and standards pursuant to § 32.1-137.9; and (x) such other requirements as the Board may establish by regulation consistent with this article.

Upon the issuance or reissuance of a certificate, the Commissioner shall provide a copy of such certificate to the Bureau of Insurance.

D. Upon determining to deny a certificate, the Commissioner shall notify such applicant in writing stating the reasons for the denial of a certificate. A copy of such notification of denial shall be provided to the Bureau of Insurance. Appeals from a notification of denial shall be brought by a certificate applicant pursuant to the process set forth in § 32.1-137.5.

E. The State Corporation Commission shall give notice to the Commissioner of its intention to issue an order based upon a finding of insolvency, hazardous financial condition, or impairment of net worth or surplus to policyholders or an order suspending or revoking the license of a managed care health insurance plan licensee; and the Commissioner shall notify the Bureau of Insurance when he has reasonable cause to believe that a recommendation for the suspension or revocation of a certificate of quality assurance or the denial or nonrenewal of such a certificate may be made pursuant to this article. Such notifications shall be privileged and confidential and shall not be subject to subpoena.

F. No certificate of quality assurance issued pursuant to this article may be transferred or assigned without approval of the Commissioner. (1998, c. 891.)

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§ 32.1-137.3. Regulations. - Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall promulgate regulations, consistent with this article, governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans on or before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist and as appropriate for the type of managed care health insurance plan. The regulations shall also include guidelines for the Commissioner to determine, in consultation with the Bureau of Insurance, when the imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or investigation conducted by the Department pursuant to provisions of this article. (1998, c. 891.)

§ 32.1-137.4. Examination, review or investigation. - A. The Commissioner shall cause each managed care health insurance plan licensee subject to certification under this article to be examined or reviewed for each new application and to be periodically examined or reviewed at reasonable times thereafter, including both for complaint investigation and for renewal compliance. Such examinations or reviews shall consider the compliance of the managed care health insurance plan licensee with the regulations promulgated under § 32.1-137.3.

In lieu of or in addition to making his own examination of the managed care health insurance plan licensee, the Commissioner may accept the report of an examination of the licensee under similar laws of another state, similar regulatory agency, state health commissioner, or accreditation entity.

B. Any examiner authorized by the Commissioner shall, so far as necessary for the purposes of the examination or review, have access during regular business hours to the premises and to any books, records, files, or property of the licensee as far as they directly relate to the quality of care provided by the licensee. All material copied or recorded or received shall be privileged and confidential and shall not be subject to subpoena.

C. Every person from whom information is sought, in an investigation of a complaint pursuant to this article against a managed care health insurance plan licensee, shall cooperate in producing or allowing reasonable access during regular business hours to the books, records, files, accounts, papers, documents, and any or all computer or other recordings of the licensee being examined or those of any person delivering health care services under contract, affiliation, delegation or other arrangement directly relevant to the investigation. Such information shall be limited to that which is relevant to the investigation in question, as specified in regulations promulgated pursuant to this article. All material copied or recorded or received shall be privileged and confidential, and shall not be subject to subpoena.

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D. The refusal of any licensee, by its officers, directors, employees or agents, to submit to examination or review or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, denial, or nonrenewal of any certificate of quality assurance held by the licensee. Any such proceedings for suspension, revocation, denial or nonrenewal of any certificate shall be conducted pursuant to § 32.1-137.5. (1998, c. 891.)

§ 32.1-137.5. Civil penalties; probation; suspension; restriction or prohibition of new enrollments to managed care health insurance plan licensee; revocation or nonrenewal of certificate of quality assurance; appeal process; correction. - A. In accordance with applicable regulations of the Board and in consultation with the Bureau of Insurance, the Commissioner (i) may impose civil penalties, which shall not exceed \$1,000 per incident of noncompliance, to a maximum of \$10,000 for a series of related incidents of noncompliance, (ii) may place a certificate holder on probation, (iii) may temporarily suspend a certificate of quality assurance of a managed care health insurance plan licensee, (iv) may, with the concurrence of the Bureau of Insurance, temporarily restrict or prohibit new enrollments into a managed care health insurance plan, or (v) may revoke or not renew a certificate of quality assurance and certify to the State Corporation Commission that a managed care health insurance plan licensee or its managed care health insurance plan is unable to fulfill its obligations to furnish quality health care services as set forth in this article. Fines payable under this section shall be paid into the Literary Fund.

B. When examination or review or complaint investigation by the Department results in a finding of noncompliance with the provisions of this article or the regulations of the Board, the managed care health insurance plan licensee or applicant shall be provided written notice and a report specifying the findings of noncompliance and providing an opportunity to be heard in no fewer than thirty days by the Commissioner's adjudication officer in a proceeding under § 2.2-4019. A copy of the notice and report shall be provided to the Bureau of Insurance. Such proceeding shall be separate from the regulatory office of the Department that conducted the examination, review, or investigation and shall be closed and confidential. The records of the proceedings shall be privileged and confidential and shall not be subject to subpoena.

The adjudication officer shall provide a recommendation to the Commissioner, including findings of fact, conclusions, and appropriate disciplinary action or sanction. The Commissioner shall promptly notify the Bureau of Insurance if the recommended disciplinary action or sanction proposes probation, suspension, nonrenewal, or revocation of a certificate of quality assurance, or the temporary restriction or prohibition of new enrollments in a managed care health insurance plan. The Commissioner may affirm, modify, or reverse such recommendation and shall issue a final decision.

The Commissioner's decision may be appealed directly to a circuit court under Article 4 (§ 2.2-4025 et seq.) of the Administrative Process Act. The only parties to the case shall

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be the managed care health insurance plan licensee and the Department. The Commissioner shall promptly notify the Bureau of Insurance of the commencement and final determination of an appeals proceeding.

C. If a certificate of quality assurance has been revoked or suspended or a certificate holder has been placed on probation, a new certificate may be issued or the suspension may be terminated or the probation removed by the Commissioner after satisfactory evidence is submitted to him that the conditions upon which revocation, suspension, or probation was based have been corrected and after proper examination has been made and compliance with all provisions of this article and the regulations of the Board has been shown. (1998, c. 891.)

§ 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 of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and the electronic mail address of the Office of the Managed Care Ombudsman established pursuant to § 38.2-5904 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 and to the Office of the Managed Care Ombudsman 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

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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 Human Resource Management 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.

E. The Commissioner shall have no jurisdiction to adjudicate individual controversies arising under this article.

F. The Commissioner of Health or the nonprofit organization pursuant to § 32.1-276.4 may prepare a summary of the information submitted pursuant to this provision and § 32.1-122.10:01 to be included in the patient level data base. (1998, cc. 744, 891; 1999, cc. 643, 649; 2000, cc. 66, 657, 922.)

**Article 1.2
Utilization Review Standards and Appeals.**

§ 32.1-137.7. Definitions. - As used in this article:

"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. When the policy, contract, plan, certificate, or evidence of coverage includes coverage for prescription drugs and the health service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse decision shall be made within twenty-four hours of the request for coverage.

"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 managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

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"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.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review organization responsible for compliance with the provisions of this article.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in the Commonwealth of Virginia or under a comparable licensing law of 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 in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States 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 services 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, managed care health insurance plan licensee, 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 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and 38.2-134.

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"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. (1998, cc. 129, 891; 1999, c. 857; 2000, c. 564.)

§ 32.1-137.8. 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 article.

B. This article 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 article shall not apply to private review agents subject to Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia.

D. This article shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services. (1998, cc. 129, 891.)

§ 32.1-137.9. Requirements and standards for utilization review entities. - A. Each entity shall establish reasonable and prudent standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases.

The entity shall make available to any provider or covered person, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws.

B. An adverse decision shall be made only in accordance with § 32.1-137.13.

C. Each entity shall have a process for reconsideration of an adverse decision in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15.

D. Each entity shall make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.

E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations.

F. Each entity shall notify its covered persons of the review process, including the appeals process, and shall so notify the covered person's provider upon written request by

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the provider. An Evidence of Coverage shall contain a clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of the process for reconsideration of an adverse decision rendered under § 32.1-137.13, as required by § 32.1-137.14, and the process for appeal from a final adverse decision under § 32.1-137.15.

G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review.

H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with § 32.1-137.11.

I. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity establish reasonable and prudent requirements and standards pursuant to this section. (1998, c. 891.)

§ 32.1-137.10. Utilization review plan required. - A. Each utilization review entity subject to this article shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of § 32.1-137.9 and other applicable provisions of this article. Such plan shall contain, at a minimum, the following:

1. Specific procedures to be used in review determinations, including an expedited review of no more than twenty-four hours for review determinations relating to prescriptions for the alleviation of cancer pain;

2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment;

3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan;

4. A provision for a process for reconsideration of adverse decisions in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15; and

5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of § 32.1-137.12.

B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request.

C. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A. (1998, c. 891; 1999, c. 857.)

§ 32.1-137.11. Accessibility of utilization review entity. - A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern

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time zone shall provide covered persons advance written notification of the eastern time zone hours during which those entities are accessible; however, such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours. (1998, c. 891.)

§ 32.1-137.12. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information. - A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later.

B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate.

C. Each entity shall have reasonable access to patient-specific medical records and information. (1998, c. 891.)

§ 32.1-137.13. Adverse decision. - A. The treating provider shall be notified in writing of any adverse decision within two working days of the decision; however, the treating provider shall be notified orally by telephone within twenty-four hours of any adverse decision for a prescription known to be for the alleviation of cancer pain. Any such notification shall include instructions for the provider on behalf of the covered person to seek a reconsideration of the adverse decision, including the contact name, address, and telephone number of the person responsible for making the adverse decision.

B. No entity shall render an adverse decision unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity. For any adverse decision relating to a prescription to alleviate cancer pain, a physician advisor shall review the issue of medical necessity with the provider. (1998, c. 891; 1999, c. 857; 2001, c. 22.)

§ 32.1-137.14. Reconsideration of adverse decision. - A. Any reconsideration of an adverse decision shall be requested by the provider on behalf of the covered person. A decision on reconsideration 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 or peer of the treating health care provider on the panel.

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The treating provider on behalf of the covered person shall be notified of the determination of the reconsideration of the adverse decision, in accordance with § 32.1-137.9, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to § 32.1-137.15.

B. Any reconsideration shall be rendered and the decision provided to the treating provider and the covered person in writing within ten working days of receipt of the request for reconsideration. (1998, c. 891.)

§ 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. Such notification shall also include the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman. Further, such notification shall advise any such covered person that, except in the instance of fraud, any such appeal herein may preclude such person's exercise of any other right or remedy relating to such adverse decision. An expedited appeals process of no more than twenty-four hours shall be established and conducted by telephone to consider any final adverse decision that relates to a prescription to alleviate cancer pain.

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

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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 treating health care provider shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration relating to a prescription to alleviate cancer pain.

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 or would subject the cancer patient to pain. 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 Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of this title, 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. (1998, c. 891; 1999, cc. 643, 649, 857; 2000, c. 922.)

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§ 32.1-137.16. Records. - Every entity subject to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 of this title and this article shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Department, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; records of complaints received, including the manner in which the complaints were resolved; the number and type of adverse decisions, and reconsiderations; the number and outcome of final adverse decisions and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records of complaints under Article 1.1 (§ 32.1-137.1 et seq.) of this chapter shall be maintained from the date of the entity's last examination and for no less than five years.

Every entity subject to utilization review under this article shall provide, upon request of the Commissioner, data and records pertaining to utilization review from which patient and provider identifiers have been removed. Records shall be maintained or caused to be maintained by the utilization review entity for a period of five years, and all such records shall be subject to examination by the Commissioner or his designee. (1998, c. 891.)

§ 32.1-137.17. Limitation on Commissioner's jurisdiction. - The Commissioner shall have the right to determine compliance with this article; however, the Commissioner shall have no jurisdiction to adjudicate individual controversies arising out of or incidental to this article. (1998, c. 891.)