

**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 2.1
Private Review Agents**

§ 32.1-138.6. Definitions. - In this chapter the following terms have the meanings indicated:

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

"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.

"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.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, health maintenance organization, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132 and 38.2-134.

"Utilization review program" means a program for conducting utilization reviews by a private review agent. (1990, c. 826, § 38.2-5300; 1995, c. 745; 1996, c. 259; 1998, c. 129; 2000, c. 564.)

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

- A private review agent may not conduct utilization reviews in the Commonwealth unless the Department has granted the private review agent a certificate of registration. The Department

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shall issue a certificate of registration to an applicant that has met the minimum standards required by this article and applicable regulations of the Department. A certificate of registration issued under this article is not transferable. (1990, c. 826, § 38.2-5301; 1998, c. 129.)

§ 32.1-138.8. Consultation with health regulatory boards. - If in the administration of this article a question concerning compliance with standards of practice governing any health care profession arises pursuant to Subtitle III (§ 54.1-2400 et seq.) of Title 54.1, the Commissioner or his designee shall consult with the appropriate health regulatory board within the Department of Health Professions. (1998, c. 129.)

§ 32.1-138.9. Standards for approval. - Each private review agent shall file an application with the Department which shall meet the following minimum standards and any additional standards established by regulation pursuant to § 32.1-138.15, and pay a filing fee established by the Department, in order to be approved by the Department: 1. A description of the procedures to be used in evaluating proposed or delivered hospital, medical, or other health care services; 2. The procedures by which patients or providers may seek reconsideration of determinations by private review agents; 3. The type and qualifications of the personnel either employed or under contract to perform the utilization review; 4. Procedures and policies which ensure that patient-specific medical records and information shall be kept strictly confidential except as authorized by the patient or by regulations adopted pursuant to this article; and 5. Assurances that reviewers be readily accessible by telephone to patients and providers at least forty hours per week during normal business hours. (1990, c. 826, § 38.2-5302; 1998, c. 129.)

§ 32.1-138.10. Expiration; renewal. - Each certificate of registration shall expire on the second anniversary of its effective date unless the certificate of registration is renewed for a two-year term as provided in this section. The Department shall renew the certificate of registration for an additional two-year term if the applicant is otherwise entitled to the certificate of registration, pays to the Department the renewal fee set by regulations, submits to the Department a renewal application on a form prescribed by the Department, submits satisfactory assurances of compliance with the requirements of this article and updates information on file with the Department pursuant to this section. (1990, c. 826, § 38.2-5303; 1998, c. 129.)

§ 32.1-138.11. Denial; revocation. - A. The Department may deny a certificate of registration to any applicant if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this article or by any regulations promulgated pursuant to this article.

B. The Department may revoke a certificate of registration, or place the holder on probation with terms and conditions, if the holder demonstrates that it is unable or unwilling to meet the requirements of this chapter or of regulations adopted pursuant to this article. (1990, c. 826, § 38.2-5304; 1998, c. 129.)

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§ 32.1-138.12. Waiver of requirements of article. - The Department shall waive the requirements of this article for a private review agent that operates under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974. (1990, c. 826, § 38.2-5306; 1998, c. 129.)

§ 32.1-138.13. Access to and confidentiality of patient-specific medical records and information. - Private review agents who have been granted a certificate of registration by the Department shall have reasonable access to patient-specific medical records and information to the extent and in the manner authorized by regulation. (1990, c. 826, § 38.2-5307; 1998, c. 129.)

§ 32.1-138.14. No private right of action created. - This article shall not be construed to create a private right of action against a private review agent on behalf of a subscriber, policyholder, member, enrollee or other person. (1990, c. 826, § 38.2-5308; 1998, c. 129.)

§ 32.1-138.15. Regulations. - The Department shall promulgate regulations, pursuant to the Administrative Process Act (§ 2.2-4000 et seq.), to implement the provisions of this article, which shall include, but not be limited to, the following items: 1. Minimum qualifications to perform review; 2. Procedures which require the private review agent to provide the attending physician an opportunity to consult with a physician advisor prior to issuance of a final denial in any case in which there is an initial recommendation to deny coverage; 3. Guidelines regarding access to and confidentiality of patient-specific medical records and information; and 4. Setting the amount of any fees required by this article, which shall be sufficient to pay for the administrative costs of regulation under this article. (1990, c. 826, § 38.2-5309; 1998, c. 129.)