H-3892.2

HOUSE BILL 2617

State of Washington 54th Legislature 1996 Regular Session

By Representatives Cody, Murray, Conway and Dellwo

Read first time 01/15/96. Referred to Committee on Health Care.

AN ACT Relating to health plan utilization review processes; and adding a new chapter to Title 48 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** These standards establish reasonable criteria for the structure and operation of health plan utilization review processes designed to facilitate ongoing assessment and management of health care services.

NEW SECTION. **Sec. 2.** These standards apply to an entity that provides or performs utilization review services.

NEW SECTION. **Sec. 3.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Adverse determination" means a determination that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

(2) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(3) "Appeals procedure" means a formal process whereby a covered person, attending physician, facility, or applicable health care provider can appeal an adverse utilization review decision rendered by the health plan or its designee utilization review organization.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or chronic health conditions that provides cost-effective and benefit-maximizing treatments for extremely resource-intensive conditions.

(5) "Certification" means a determination by a health plan or its designee utilization review organization that an admission or continued stay, or other covered health care service satisfies the health plan’s clinical requirements for appropriateness, necessity, health care setting, and level of care.

(6) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written screening procedures, decision abstracts clinical protocols, and practice guidelines used by the health plan to determine necessity and appropriateness of health care services.

(8) "Concurrent review" means utilization review conducted during a patient’s hospital stay or course of treatment.

(9) "Covered person" means a member, enrollee, subscriber, covered life, patient, or other person eligible to receive benefits under a health plan.

(10) "Discharge planning" means the formal process for determining, coordinating, and managing the care a patient receives following discharge from a facility.

(11) "Emergency" means medically necessary health care services that are immediately required because of unforeseen illness or injury.

(12) "Facility" means an institution or health care setting rendering the prescribed health care service under review. These institutions include, but are not limited to, hospitals and other licensed inpatient facilities, ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers,

diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health care settings.

(13) "Health plan" means any policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(14) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

(15) "Provider" means physician, organized group of physicians, facility, or other health care professional licensed or certified by this state, where licensure or certification is required.

(16) "Retrospective review" means utilization review conducted after services have been provided to a patient, but does not include retrospective review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, and adjudication for payment.

(17) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(18) "Utilization review" means a set of formal techniques designed to monitor and evaluate the clinical necessity, appropriateness, and efficiency of health care services, procedures, providers, and facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review.

(19) "Utilization review organization" means an entity that conducts utilization review.

NEW SECTION. **Sec. 4.** (1) The corporate board of a health plan, or a committee or designated executive staff specifically appointed by the board for this purpose, is responsible for the health plan utilization review activities.

(2) The corporate board of a health plan, or its designee appointed under subsection (1) of this section, must approve the written utilization review program, including functions delegated to a utilization review organization, and must periodically review and revise the program document to assure ongoing appropriateness. The

program must include a description of all utilization review activities performed, as required by section 5 of this act.

(3) Periodically, but no less than semiannually, the corporate board, or its designee appointed under subsection (1) of this section, must review reports of utilization review activities, including appeals.

NEW SECTION. **Sec. 5.** (1) The health plan must implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program must include and the program document must describe, at a minimum:

(a) Procedures to evaluate clinical necessity, appropriateness, and efficiency of health services, and processes to detect under as well as over-utilization of services;

(b) Data sources and clinical review criteria used in decision making;

(c) The process for conducting appeals of adverse utilization review decisions;

(d) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(e) Data collection processes and analytical methods that may be used in assessing utilization of health care services;

(f) Provisions for assuring confidentiality of clinical information;

(g) The organizational structure, such as utilization review committee, quality assurance, or other committee that periodically assesses utilization review activities and reports to the governing body, or its designee; and

(h) The staff position functionally responsible for day-to-day program management.

(2) An annual summary report of utilization review program activities must be filed with the appropriate regulatory agency or as otherwise required by law. Must be aggregated and must preserve the confidentiality of information pertaining to individual covered persons. The insurance commissioner or other state official as provided by law has the authority to request additional information.

NEW SECTION. **Sec. 6.** (1) The utilization review program must use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy.

(a) The clinical review criteria used in conjunction with an adverse determination must be made available, upon request, to affected providers and covered persons.

(b) The clinical review criteria must be made available, upon request, to authorized government agencies.

(c) The clinical review criteria must be developed with involvement from the appropriate actively practicing physicians and other appropriate actively practicing licensed health care providers.

(2) Qualified health care professionals must administer the utilization review program and oversee review decisions. Board-certified physicians must be utilized when appropriate. A licensed, board-certified clinical practitioner must evaluate the clinical appropriateness of adverse utilization review decisions.

(3) Utilization review decisions must be issued in a timely manner under the requirements of section 7 of this act.

(a) All information required to make a utilization review decision must be obtained, including pertinent clinical information and consultation with the treating provider. Treating providers must submit requested information in a timely manner to facilitate the decision.

(b) There must be a process to assure that utilization reviewers consistently apply clinical review criteria.

(c) Adverse determinations must satisfy the requirements of section 8 of this act.

(4) The health plan must routinely assess the effectiveness and efficiency of the utilization review program.

(5) Data systems must be sufficient to support utilization review program activities and to generate management reports to enable the health plan to effectively monitor and manage health care services.

(6) If the health plan delegates utilization review activities to a utilization review organization, adequate oversight must be maintained, and must include:

(a) A written description of utilization review organization activities and responsibilities, including reporting requirements;

(b) Evidence of formal approval of the utilization review organization program by the health plan; and

(c) A process for evaluating the performance of the utilization review organization.

(7) Utilization review program activities must be coordinated with other medical management activity including, but not limited to, quality assurance, credentialing, provider contracting, data reporting, member satisfaction assessment processes, and risk management.

(8) The health plan or its designee utilization review organization must provide access to its review staff by a toll-free number or collect call phone line during normal business hours.

(9) When conducting utilization review, the health plan or its designee utilization review organization must collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, or duration of services.

NEW SECTION. **Sec. 7.** (1) Certification decisions regarding a proposed admission, service, or procedure must be made within two business days of obtaining all necessary information upon which to base a decision. It is the responsibility of all parties involved in the certification to facilitate this process.

For purposes of this section, "necessary information" includes the results of any second opinion that may be required or receipt of other factual or clinical information.

(2) Certification notices must be provided within twenty-four hours by telephone or in writing to the provider or facility and to the covered person. Written or electronic confirmation of telephone certification must be transmitted within two business days of the certification.

(3) Concurrent review certifications of a continued stay in a facility or additional health care services must be communicated via telephone within twenty-four hours and written or electronic confirmation must be sent within one business day to the provider or facility. Extended stay certifications must identify the additional approved number of days or additional services approved.

NEW SECTION. **Sec. 8.** (1) Adverse determinations or noncertifications of admissions, continued stays, or services must be clearly documented, including the specific clinical or other reason for the adverse determination, and must be available to the covered person and affected provider or facility. Notice to the provider or facility

must be issued by telephone within twenty-four hours of the adverse determination. Written or electronic confirmation must be transmitted to the provider or facility and the covered person within one business day of the adverse determination.

(2) Retrospective review denials must be issued in writing within five working days of obtaining all necessary information constituting the adverse determination, and must include the reason for the determination.

(3) Written notice of an adverse determination must include a description of the appeal procedures, and instructions for initiating an appeal.

NEW SECTION. **Sec. 9.** (1) The health plan must establish written procedures for standard and expedited appeals of decisions not to certify an admission, continued stay, procedure, or service. Appeal procedures must be available to the covered person and to the attending or ordering provider.

(2) Appeals must be evaluated by an appropriate clinical peer professional in the same or similar specialty as would typically manage the case being reviewed, or another licensed health care professional as mutually agreed upon by the parties. The agreement is void if made prior to the initial determination. The health care peer professional must not have been involved in the initial adverse determination.

(3) For standard appeals, the health plan must notify in writing the covered person, and the attending or ordering provider of the decision on the appeal. Notice must be timely, but in no event more than thirty days following the request for appeal.

(4) For emergency appeals, the health plan must make every reasonable effort to process the request within seventy-two hours and to issue a decision no later than one business day following receipt of all necessary information. It is the responsibility of all parties involved in the appeal to facilitate this process. An expedited appeal is available only when the standard appeal process would cause a delay in care that could be detrimental to the health of the covered person.

NEW SECTION. **Sec. 10.** (1) The health plan must establish and implement written policies and procedures to assure that patient-specific clinical information and provider-specific performance data obtained as a result of utilization review activities are maintained in

a confidential manner. Policies and procedures must include, at a minimum:

(a) Safeguards to protect against unauthorized use or disclosure;

(b) Guidelines for reporting and release of data to promote the availability of useful, understandable, and accurate information;

(c) Mechanisms to assure that data reports related to utilization patterns and quality of care have as their primary purpose to educate and inform users of the data, including a corporate board or designee, plan administrators, payers, consumers, and providers in order to make meaningful selections and decisions regarding the provision of health care services;

(d) Processes to assure data are statistically sound and collected, analyzed, and reported according to methodologies that are deemed accurate, reliable, meaningful, and valid;

(e) Reasonable opportunities for affected parties to review and respond to data reports before their release;

(f) Mechanisms to assure data are severity-adjusted to account for patient and outcome differences;

(g) Reports that are generated according to equitable selection criteria so that no class of provider is held to a greater standard of public accountability;

(h) Guidelines to prevent unauthorized release of patient-specific data to the public; and

(i) Provisions that a party making reports available to the public is held accountable for failure to comply with a standard of due care or safeguards that incorporate criteria for proper release described in these standards.

(2) Information pertaining to the diagnosis, treatment, or health of a covered person may be disclosed only to authorized persons to carry out the obligations of the health plan. Release of information otherwise is only permitted with the express consent of the covered person, or under court order for the production of evidence or discovery, or as otherwise provided by law.

NEW SECTION. **Sec. 11.** (1) In materials intended for prospective covered persons, the health plan must include a summary of its utilization review procedures.

(2) In the certificate of coverage or member handbook provided to newly enrolled covered persons, the health plan must include a clear

and comprehensive description of its utilization review procedures and a statement of patient rights and responsibilities with respect to those procedures.

(3) The health plan must disclose to the insurance commissioner or other designated state official utilization review program policies, procedures, reports, and data that are required by law.

(4) The health plan must state on its membership cards a toll-free telephone number to call for precertification decisions.

NEW SECTION. **Sec. 12.** Sections 1 through 11 of this act shall constitute a new chapter in Title 48 RCW.

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