HOUSE BILL NO. 701

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Labor and Commerce

on _____)

(Patron Prior to Substitute—Delegate Maldonado)

A BILL to amend and reenact §§ 32.1-137.13 and 38.2-3559 of the Code of Virginia, relating to health and health insurance; notice of adverse determination.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.13 and 38.2-3559 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-137.13. Adverse determination.

A. The treating provider shall be notified in writing of any adverse determination within two working days of the determination; however, the treating provider shall be notified orally by telephone within 24 hours of any adverse determination 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 (i) seek a reconsideration of the adverse determination pursuant to § 32.1-137.14, including the contact name *or unique identifier*, address, and telephone number of the person responsible for making the adverse determination, and (ii) seek an appeal of the adverse determination pursuant to § 32.1-137.15, including the contact name *or unique identifier*, address, and telephone number to file and perfect such appeal.

B. No entity shall render an adverse determination unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its determination, 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 determination relating to a prescription to alleviate cancer pain, a physician advisor shall review the issue of medical necessity with the provider.

§ 38.2-3559. Notice of right to external review.

A. A health carrier shall notify the covered person in writing of an adverse determination or final adverse determination and the covered person's right to request an external review *within five business days after the adverse determination or final adverse determination has been made*. ~~The notice of the right to request an external review~~ *Such notice* shall include the following, or substantially similar, language *in prominent bold print*: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness,

health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission." *Such notice shall also include the name of or unique identifier for, and business address and telephone number of (i) if the carrier is a health maintenance organization, the medical director or associate medical director, as appropriate, who made the adverse determination or (ii) if the carrier is not a health maintenance organization, the designated employee or representative of the carrier who has responsibility for the carrier's internal appeal process and the provider who is required to made the adverse determination.*

B. The notice of the right to request an external review of an adverse determination shall include the following statements informing the covered person that:

1. If the covered person's adverse determination involves (i) cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3562;

2. If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3563;

3. If the covered person or his authorized representative files a request for an expedited internal appeal with the health carrier, he may file at the same time a request for an expedited external review of an adverse determination pursuant to § 38.2-3562 or 38.2-3563. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review; and

4. If the covered person or his authorized representative files a standard appeal with the health carrier's internal appeal process, and the health carrier does not issue a written decision within 30 days following the date the appeal requesting a review is filed and the covered person or his authorized representative did not request or agree to a delay, the covered person or his authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process.

C. The notice of the right to request an external review of a final adverse determination shall include the

following statements informing the covered person that:

1. If the covered person has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3562;

2. If the final adverse determination involves an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or his authorized representative may request an expedited external review pursuant to § 38.2-3562; and

3. If the final adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or his authorized representative may file a request for a standard external review pursuant to § 38.2-3563; or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may request an expedited external review pursuant to subsection B of § 38.2-3563.

D. The health carrier shall include the standard and expedited external review procedures and any forms with the notice of the right to an external review.