ALFRED W. GROSS
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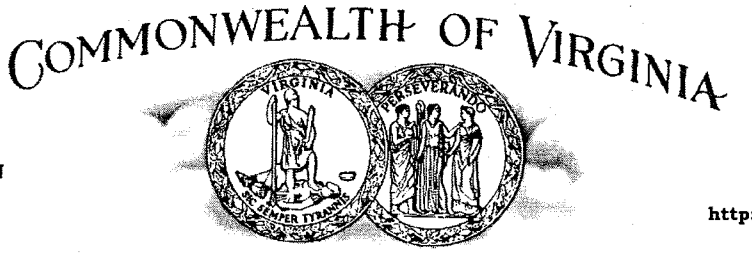
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

June 29, 2007

Administrative Letter 2007-7

TO: All Managed Care Health Insurance Plans and Interested Parties

RE: Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (14 VAC 5-215-10 et seq.)

As the result of 2007 House Bill 3137, changes were made to Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia relating to the independent external review of final adverse utilization review decisions. The State Corporation Commission also recently adopted changes to the *Rules Governing Independent External Review of Final Adverse Utilization Review Decisions* (Rules), at 14 VAC 5-215-10 et seq. to address the recent legislative changes. This letter serves to identify a number of these changes and to provide guidance to carriers in implementing them. *The statutory and regulatory changes will take effect on July 1, 2007.*

Among the significant statutory changes resulting from House Bill 3137 are the following:

- A provision for expedited consideration of appeals involving a terminal condition has been included;
- The Commissioner of Insurance or his designee must issue a written ruling affirming, modifying, or reversing a final adverse decision no later than one business day following receipt of the assigned impartial health entity's recommendation concerning a condition that would be terminal without the requested treatment; and
- The failure by the utilization review entity to comply with the written ruling of the Commissioner or his designee within three business days following receipt by the utilization review entity of an expedited ruling shall be deemed a knowing and willful violation.

Similarly, the Rules were revised to address the above legislation. The following significant changes should be noted:

- 14 VAC 5-215-30 – the definition of "Emergency medical condition" was revised to include a health condition which would be terminal without the requested treatment, as determined by the person's treating health care provider.

- 14 VAC 5-215-80 was revised to state that if the decision is regarding treatment for a covered person whose condition would be terminal without the treatment, the Commissioner of Insurance or his designee shall issue his written ruling no later than one business day following the receipt of the recommendation.

A copy of the revised Rules and forms is attached. In addition, this Administrative Letter and the new forms will also be available on the Bureau's website at:

http://www.scc.virginia.gov/division/boi/webpages/boiadministrativeltrselection.htm

Questions relating to this Administrative Letter should be directed to:

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Cordially,

Alfred W. Gross
Commissioner of Insurance

Attachments

CHAPTER 215.

RULES GOVERNING INDEPENDENT EXTERNAL REVIEW OF FINAL ADVERSE UTILIZATION REVIEW DECISIONS

14 VAC 5-215-10. Scope and purpose.

A. This chapter shall apply to all utilization review entities as that term is defined in 14 VAC 5-215-30, the issuer of a covered person's policy or contract of health benefits, and covered persons.

B. This chapter shall not apply to utilization review performed under contract with the federal government for patients eligible for health care services under Title XVIII of the Social Security Act (42 USC §1395 et seq.), utilization review performed under contract with the federal government for patients eligible for health care services under the TRICARE program (10 USC §1071 et seq.), or utilization review performed under contract with a plan otherwise exempt from the operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.).

This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

C. The purpose of this chapter is to set forth rules to carry out the provisions of Chapter 59 (§38.2-5900 et seq.) of Title 38.2 of the Code of Virginia so as to provide (i) a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions made by a utilization review entity; (ii) procedures for expedited consideration of appeals in cases of emergency health care; and (iii) standards, credentials, and qualifications for impartial health entities.

14 VAC 5-215-20. Notifications.

In the event of a final adverse decision, a utilization review entity shall provide to the covered person or treating health care provider requesting the decision a clear and understandable written notification of (i) the right to appeal final adverse decisions to the Bureau of Insurance in accordance with the provisions of Chapter 59 (§38.2-5900 et seq.) of Title 38.2 of the Code of Virginia; (ii) the procedures for making such an appeal; and (iii) the binding nature and effect of such an appeal. The notice shall include a copy of the Instructions (Form 215A), Important Terms and Definitions (Form 215B), Appeal of Final Adverse Decision Form (Form 215C), and Authorization (Form 215D), or such other form or forms as may then be required by the Bureau of Insurance pursuant to 14 VAC 5-215-120.

14 VAC 5-215-30. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

"Appellant" means (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care

provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated.

"Commission" means the Virginia State Corporation Commission.

"Commissioner" means the Commissioner of Insurance.

"Covered person" means an individual, whether a policyholder, subscriber, enrollee, covered dependent, 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 as defined in and subject to regulation under Chapter 58 (§38.2-5800 et seq.) of Title 38.2 of the Code of Virginia, when such coverage is provided under a contract issued in this Commonwealth.

"Emergency health care" means health care items and medical services furnished or required to evaluate and treat an emergency medical condition.

"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition or illness that if not treated within the time frame allotted for a standard review under this chapter will result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition that would be terminal without the requested treatment, as determined by the person's treating health care provider.

"Evidence of coverage" means 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.

"Final adverse decision" means a utilization review determination (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition after granting an expedited review; or (iii) denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 of the Code of Virginia have been exhausted. For purposes of this chapter, a final adverse decision shall be deemed to have been made on the date that it is communicated to the covered person or treating health care provider.

"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. As used herein, "utilization review" shall include, but shall 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 also include determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. "Utilization review" shall not include any: (i) denial of benefits or services for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) 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 of the Code of Virginia.

"Utilization review entity" or "entity" means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse decision.

14 VAC 5-215-40. Minimum appealable amount.

A. Appeals of final adverse decisions may be made to the Bureau of Insurance provided that the actual cost of the health care service or services to the covered person would exceed $300 if the final adverse decision is not reversed. The cost of the health care service or services shall be determined by the amount the covered person has paid or has incurred a legal obligation to pay for such service or services, as well as the amount that the covered person would be obligated to pay in the event that the final adverse decision is not reversed.

B. The health care service or services must meet the following criteria in order to be eligible for an external review as provided by this chapter:

1. The service or services, as described by the most recent published editions of the applicable International Classification of Diseases 9th Revision Clinical Modification, Physician's Current Procedural Terminology, Diagnostic Related Groups, or other billing code, must have a minimum value, as defined in subsection A of this section, that exceeds $300.

2. No covered person or provider shall engage in "bundling" techniques designed to combine the value of denied services such that the actual cost to the covered person of denied services artificially exceeds $300.

3. The commissioner, or his designee, shall have the final undisputed authority to determine if the actual cost to the covered person of the denied services exceeds $300.

14 VAC 5-215-50. Appeals.

A. An appeal of a final adverse decision made by a utilization review entity shall be submitted to the Bureau of Insurance within 30 days of the final adverse decision. The appeal shall be made by (i) completing and signing a copy of the Appeal of Final Adverse Decision Form, (Form 215C) or such other form or forms as may then be required by the Bureau of Insurance pursuant

to 14 VAC 5-215-120; (ii) completing and signing an Authorization to Release Medical Information (Form 215D) in a form and manner required by the Bureau of Insurance; and (iii) forwarding a check or money order made payable to the Treasurer of Virginia in the amount of $50. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity that made the final adverse decision.

B. The $50 fee required to file an appeal may be waived or refunded for good cause shown upon a determination by the Bureau of Insurance that payment of the filing fee will cause undue financial hardship for the covered person. Such determination shall be based upon information provided on the Appeal of Final Adverse Decision Form (Form 215C) required by the Bureau of Insurance, and any supplemental information required by the Bureau of Insurance. The decision of the Bureau of Insurance as to whether good cause has been shown that payment of the filing fee will cause undue financial hardship shall be final.

C. A preliminary review of the appeal shall be conducted by the Bureau of Insurance or its designee to determine the following: (i) that the person on whose behalf the appeal has been filed is, or was, a covered person at the time the health care service in question was requested; (ii) that the appellant satisfies the definition of "appellant" set forth in 14 VAC 5-215-30; (iii) that the benefit or service that is the subject of the appeal reasonably appears to be a covered service for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed; (iv) that all other appeal procedures available to the appellant have been exhausted, except in the case of an appeal accepted as one requiring expedited review; and (v) that the appeal is otherwise complete and filed in accordance with this section. The Bureau of Insurance shall not accept an appeal that does not meet the foregoing requirements.

D. The preliminary review shall be conducted within 10 working days of receipt of all information and documentation necessary to conduct the preliminary review.

E. The Bureau of Insurance shall notify the appellant and the utilization review entity in writing within five working days of the completion of the preliminary review whether the appeal has been accepted for review, and if not accepted, the reason or reasons.

F. The appellant, the treating health care provider, if not the appellant, and the utilization review entity shall provide to the Bureau of Insurance or its designee copies of all medical records relevant to the final adverse decision within 20 working days after the Bureau of Insurance has mailed, via certified mail, return receipt requested, written notice of its acceptance of the appeal. Failure to comply with the request within the required time may result in the dismissal of the appeal or reversal of the final adverse decision, at the discretion of the commissioner. The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

G. The Bureau of Insurance, or its designee, may request additional medical records from the appellant, the treating health care provider, if not the appellant, or the utilization review entity. Such medical records shall be provided to the entity making the request, whether the Bureau of Insurance or its designee, within 20 working days of the request. The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. Failure to comply with the request within the required time may result in dismissal of the appeal or reversal of the final adverse decision at the discretion of the commissioner.

H. The commissioner, upon good cause shown, may provide an extension of time for the covered person, the treating health care provider, the utilization review entity and the Bureau of Insurance to meet the time requirements set forth in this section.

I. If an appeal that is reviewed as an expedited appeal by a utilization review entity results in a final adverse decision, the utilization review entity shall take the following actions immediately: (i) notify the person who requested the expedited review of the final adverse decision; and (ii) notify the appellant, by telephone, fax, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance without the necessity of providing the justification required pursuant to subdivision 1 of 14 VAC 5-215-80. The notification shall be followed within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms (Forms 215A, 215B, 215C, and 215D) by which the appeal to the Bureau of Insurance may be filed. A copy of this written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

J. If a request for an expedited review is denied by a utilization review entity, the entity shall take the following actions immediately: (i) notify the appellant of the decision by telephone, fax, or electronic mail; and (ii) inform the appellant that the appellant has the right to file a request for an expedited appeal with the Bureau of Insurance pursuant to subdivision 1 of 14 VAC 5-215-80. This notification shall be followed within 24 hours by a written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms (Forms 215A, 215B, 215C, and 215D) by which the appeal to the Bureau of Insurance may be filed. A copy of the written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

K. If the Bureau of Insurance, or its designee, determines that a request for an expedited review which has been reviewed in accordance with subsection J of this section does not meet its criteria for an expedited review, the appellant shall be notified in writing by the Bureau of Insurance, or its designee, within two working days from the time the determination is made. The notice shall instruct the appellant wishing to pursue the appeal to contact the issuer of coverage and request a review through the standard review process of the issues for which an expedited review was sought.

14 VAC 5-215-60. Impartial health entity.

The Bureau of Insurance shall contract with one or more impartial health entities to perform the review of final adverse decisions made by utilization review entities. The impartial health entity shall examine the final adverse decision and determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person. The impartial health entity shall issue its written recommendation affirming, modifying, or reversing the final adverse decision within 30 working days of the date that the impartial health entity has received from all parties all documentation and information necessary for it to complete its review in the case of a standard review as set forth in 14 VAC 5-215-70. In the case of an expedited review, the impartial health entity shall issue its written recommendation within five working days of its receipt of sufficient information to review the appeal.

14 VAC 5-215-70. Standard review.

A. The Bureau of Insurance, within five working days following its acceptance of an appeal, shall assign an impartial health entity with which it has contracted pursuant to 14 VAC 5-215-60 to conduct an external review and to provide a written recommendation to the commissioner as to whether to affirm, modify, or reverse the final adverse decision.

B. In reaching a recommendation, the assigned impartial health entity is not bound by any decisions or conclusions reached during the utilization review entity's utilization review process.

C. In lieu of providing records to the Bureau of Insurance pursuant to 14 VAC 5-215-50 F, the utilization review entity, the appellant or the treating health care provider, if not the appellant, shall provide to the assigned impartial health entity all documents, medical records, and other information relevant to and relied upon by the utilization review entity in reaching its final adverse decision within 20 working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal pursuant to 14 VAC 5-215-50 E. The confidentiality of medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

D. Except as provided in subsection E of this section, failure of the utilization review entity to provide the documents, medical records and information within the time specified in subsection C of this section shall not delay the conduct of the external review.

E. 1. Upon receipt of a notice from the assigned impartial health entity that the utilization review entity, appellant, or the treating health care provider, if not the appellant, has failed, without good cause, as determined by the commissioner in his sole discretion, to provide the documents, medical records, and information within the time specified in subsection C of this section, the commissioner may terminate the external review and make a decision to affirm or reverse the final adverse decision.

2. Immediately upon making the decision pursuant to subdivision 1 of this subsection, the commissioner shall communicate his decision in writing to the assigned impartial health entity, the appellant and the utilization review entity.

F. The assigned impartial health entity shall review all of the relevant information and documents received pursuant to subsection C of this section and any other information submitted in writing by the appellant that has been forwarded to the impartial health entity by the Bureau of Insurance.

G. In addition to the documents and information provided pursuant to subsection C of this section, the assigned impartial health entity, to the extent the information is available and the impartial health entity considers them appropriate, shall consider the following in making its recommendation:

1. The treating health care provider's recommendation;

2. Consulting reports from appropriate health care providers and other documents submitted by the utilization review entity, the appellant, or the covered person's treating health care provider, if not the appellant;

3. The terms of coverage under the covered person's health benefit plan;

4. The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

5. Any applicable clinical review criteria developed or used by the utilization review entity.

H. The assigned impartial health entity shall include in its recommendation provided pursuant to 14 VAC 5-215-60:

1. A general description of the reason or reasons for the request for external review;

2. The date the impartial health entity received the assignment from the Bureau of Insurance to conduct the external review;

3. The dates the external review began and concluded;

4. The date of its recommendation;

5. The principal reason or reasons for its recommendation;

6. The rationale for its recommendation; and

7. References to the evidence or documentation, including the practice guidelines or clinical criteria, considered in reaching its recommendation.

I. 1. Immediately upon receipt of the assigned impartial health entity's recommendation, the commissioner shall review the recommendation to ensure that it is not arbitrary or capricious.

2. The commissioner shall notify the appellant and the utilization review entity in writing of the decision to uphold or reverse the final adverse decision by issuing a written ruling affirming, modifying or reversing the final adverse decision. The written ruling shall bind the covered person and the issuer of the covered person's policy or contract for health benefits to the same extent to which each would have been bound by a judgment entered in an action at law or in equity with respect to the issues which the impartial health entity may examine when reviewing a final adverse decision.

3. The commissioner shall include in the notice sent pursuant to subdivision 2 of this subsection:

a. The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner that the commissioner considers appropriate, the information provided by the assigned impartial health entity supporting its recommendation; and

b. If applicable, the principal reason or reasons why the commissioner did not follow the assigned impartial health entity's recommendation.

4. Upon notice of a decision pursuant to subdivision 1 of this subsection reversing the final adverse decision, the utilization review entity immediately shall approve and provide, or provide reimbursement for, any and all medical services that were the subject of the final adverse decision.

14 VAC 5-215-80. Expedited review.

Appeals presented to the Bureau of Insurance as requiring emergency health care shall be evaluated as follows:

1. Immediately upon receipt of an appeal indicating that emergency health care is required and otherwise meeting the requirements for review as provided in 14 VAC 5-215-50 C, the Bureau of Insurance shall consult with the impartial health entity to which the appeal normally would be assigned, and such entity shall determine if the appeal involves emergency health care.

2. If, after consultation with the impartial health entity, a determination is made by the Bureau of Insurance that the appeal does not qualify for an expedited review, the person making the request for the expedited review shall be notified within two working days of receipt by the Bureau of Insurance of sufficient information to support the request for expedited review. The declination by the Bureau of Insurance to provide an expedited review shall not preclude the appellant from resuming the normal appeal process within the utilization review entity or from filing a request for a standard review by the Bureau of Insurance, provided the requirements set forth in 14 VAC 5-215-50 A have been met.

3. Immediately upon acceptance of an appeal for expedited review, the Bureau of Insurance shall notify the utilization review entity and the appellant by the most expeditious means available, including telephone, fax, or electronic mail, of their right to submit information and supporting documentation. Such information shall be submitted to the Bureau of Insurance or the impartial health entity within two working days of the acceptance of the appeal.

4. Upon the acceptance of the appeal for expedited review, the Bureau of Insurance shall assign the appeal to an impartial health entity for clinical review as provided in 14 VAC 5-215-60. The impartial health entity shall review the appeal and make a decision as required under 14 VAC 5-215-60 as soon as possible consistent with the medical exigencies of the case, but in no event more than five working days after its receipt of sufficient information to review the appeal.

5. a. Immediately upon receipt of the assigned impartial health entity's recommendation, the commissioner shall review the recommendation to ensure that it is not arbitrary or capricious.

b. The commissioner shall notify the appellant and the utilization review entity in writing of the decision to uphold or reverse the final adverse decision by issuing a written ruling affirming, modifying or reversing the final adverse decision. The written ruling shall bind the covered person and the issuer of the covered person's policy or contract for health benefits to the same extent to which each would have been bound by a judgment entered in an action at law or in equity with respect to the issues which the impartial health entity may examine when reviewing a final adverse decision. If the decision is regarding treatment for a covered person whose condition would be terminal without the treatment, the commissioner or his designee shall issue his written ruling no later than one business day following the receipt of the recommendation.

c. The commissioner shall include in the notice sent pursuant to subdivision 5 b of this section:

(1) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner that the commissioner considers appropriate, the information provided by the assigned impartial health entity supporting its recommendations; and

(2) If applicable, the principal reason or reasons why the commissioner did not follow the assigned impartial health entity's recommendation.

d. Upon notice of a decision pursuant to subdivision 5 a of this section reversing the final adverse decision, the utilization review entity immediately shall approve and provide, or provide reimbursement for, any and all medical services that were the subject of the final adverse decision.

14 VAC 5-215-90. Reconsideration of final adverse decision.

A. The utilization review entity may reconsider its final adverse decision that is the subject of the external review at any time.

B. Reconsideration by the utilization review entity of its final adverse decision shall not delay or terminate the external review.

C. The external review may be terminated if the utilization review entity decides, upon completion of its reconsideration, to reverse its final adverse decision and provide coverage or payment for the health care service that is the subject of the final adverse decision.

D. 1. Immediately upon making the decision to reverse its final adverse decision, the utilization review entity shall notify the appellant, the assigned impartial health entity, and the commissioner in writing of its decision.

2. The assigned impartial health entity shall terminate the external review upon receipt of the notice from the utilization review entity sent pursuant to subdivision 1 of this subsection.

14 VAC 5-215-100. Payment of fees.

Any utilization review entity that: (i) reverses a final adverse decision that has already been assigned to an impartial health entity for review; or (ii) is required to provide previously denied services as a result of the commissioner's written ruling shall be responsible for the payment of the actual costs, as determined by the Bureau of Insurance, incurred by the commission for the services performed by the impartial health entity in the course of such review. This payment shall be made within 30 days of notification to the utilization review entity of the actual costs incurred.

14 VAC 5-215-110. Standards, credentials, and qualifications of the impartial health entity.

A. In order to qualify to perform either standard or expedited external reviews pursuant to this chapter and Chapter 59 (§38.2-5900 et seq.) of Title 38.2 of the Code of Virginia, an impartial health entity shall have and maintain written policies and procedures that govern all aspects of the standard and expedited external review processes that include, at a minimum:

1. A quality assurance mechanism in place that ensures:

a. External reviews are conducted within the specified time frames and required notices are provided in a timely manner;

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the impartial health entity and suitable matching of reviewers to specific cases;

c. The confidentiality of medical records is maintained in accordance with the confidentiality and disclosure laws of the Commonwealth; and

d. Any person employed by or under contract with the impartial health entity adheres to the requirements of this chapter as well as Chapter 59 of Title 38.2 of the Code of Virginia; and

2. An agreement to maintain and provide to the commission the information set out in Chapter 59 of Title 38.2 of the Code of Virginia.

B. All clinical peer reviewers assigned by an impartial health entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions as the covered person's;

3. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A of this section, an impartial health entity shall not be affiliated with or a subsidiary of nor be owned or controlled by a health plan, a trade association of health plans, or a professional association of health care providers.

D. 1. In addition to the requirements set forth in subsections A, B, and C of this section, to be qualified to perform an external review of a specified case pursuant to this chapter, neither the impartial health entity selected to conduct the external review nor any clinical peer reviewer assigned by the impartial health entity to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. The utilization review entity that made the final adverse decision that is the subject of the external review;

b. The covered person whose treatment is the subject of the external review;

c. Any officer, director or management employee of the utilization review entity that made the final adverse decision which is the subject of the external review;

d. The health care provider, the health care provider's medical group or independent practice association recommending the health care service or services subject to the external review;

e. The facility at which the recommended health care service was or would be provided; or

f. The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical peer reviewer of the impartial health entity has a material, professional, familial or financial conflict of interest for purposes of subdivision 1 of this subsection, the commissioner may take into consideration situations where the impartial health entity to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the impartial health entity to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subdivision 1 of this subsection, but the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest sufficient to disqualify the impartial health entity or the clinical peer reviewer from conducting the external review.

14 VAC 5-215-120. Modification of forms.

The Bureau of Insurance shall be permitted to modify forms prepared for use in connection with this chapter as needed without requiring amendment to this chapter. Any modifications shall be provided to all insurers licensed to market health insurance, all licensed health maintenance organizations, and all licensed health services plans in the form of an administrative letter prepared by the Bureau of Insurance and sent by regular mail to such licensee's mailing address as shown in the records of the Bureau of Insurance. Failure to receive such administrative letter shall not be cause for exemption or grounds for noncompliance with the requirements set forth in this chapter. All original and subsequently modified forms shall be filed by the Bureau of Insurance for publication in the Virginia Register of Regulations.

14 VAC 5-215-130. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

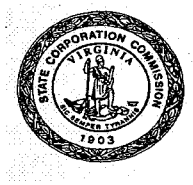
FORMS

Instructions for Completing the Appeal of Final Adverse Decision Form, Form 215A (rev. 7/07).

Important Terms and Definitions, Form 215B (rev. 7/07).

Appeal of Final Adverse Decision Form, Form 215C (rev. 7/07).

Authorization to Release Medical Information, Form 215D (rev. 7/07).



State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

INSTRUCTIONS FOR COMPLETING THE APPEAL OF FINAL ADVERSE DECISION FORM

Please Read Carefully Before Completing the Form

Before completing the attached form, please read the following instructions carefully. We also recommend that you review the form itself as well as the "Important Terms and Definitions" list attached.

The law requires that in order to be "appealable" the actual cost to the covered person of the services or procedures in question exceed $300 if the final adverse decision is not reversed. Please verify the cost of the service(s) before requesting an appeal of a final adverse decision.

1. **Name and Address**
   Please type (or print) the covered person's full name. Include the address, daytime telephone number, date of birth, sex and policy number, certificate number, or other identifying number of the covered person.

2. **Appellant Information**
   This section is to be completed by the appellant who is making the appeal on behalf of the covered person. This section does not need to be completed if the covered person is requesting the external review on his own behalf.

3. **Name of the Managed Care Health Insurance Plan**
   Please provide the name, address and telephone number of the Managed Care Health Insurance Plan (MCHIP). The MCHIP name should be the same as the insurance company or health maintenance organization providing the covered person's coverage. If the covered person is covered by insurance through an employer, please provide the name, address and phone number of the employer, if available.

4. **Describe the Covered Person's Situation**
   Please clearly and accurately describe the nature of the circumstances surrounding the covered person's request for an appeal of a final adverse decision.

5. **Expedited Review**
   In certain situations, an expedited review of an appeal of a final adverse decision may be requested. Please review the definition of "emergency medical condition" provided with this form. If the situation involves an "emergency medical condition," please indicate this by checking the "yes" box and attach supporting documentation.

6. **Treatment for Terminal Conditions**
   Please indicate whether the requested treatment has already been provided and whether, in the opinion of the covered person's treating health care provider, the covered person's condition would be terminal without this treatment.

7. **Filing Fee Waiver**
   Please note that the $50 filing fee may be waived. If you wish to request that the filing fee be waived, please describe the reason or reasons for the request and provide supporting documentation.

8. **Total Cost of Denied Services**
   Please provide an estimate of the total cost to you if services remain denied. If a prescription drug has been denied, please estimate the cost for the length of the prescription. This cost estimate is for our records and will not have any bearing on any party's payment responsibility following the final decision.

9. **Authorization/Authorization to Release Medical Information**

   Please carefully read the "Authorization" section on the "Appeal of Final Adverse Decision" form and the separate "Authorization to Release Medical Information" form included with this package. Information that you provide or authorize to be released may be shared with an impartial health entity. The signature of the covered person or other authorized signature is required on both of these forms in order for the appeal of the final adverse decision to occur.

State Corporation Commission
Bureau of Insurance
External Appeals
P.O. Box 1157
Richmond, VA 23218
(804) 371-9913

IMPORTANT TERMS AND DEFINITIONS

"Appellant" - means (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Covered person" - means an individual, whether a policyholder, subscriber, enrollee, covered dependent, or a 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 as defined in and subject to regulation under Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia, when such coverage is provided under a contract issued in this Commonwealth.

"Cost of Service" - the total amount paid by the covered person for a rendered service or the assumed liability for that service by the covered person for a rendered service. The law requires that in order for an appeal of a final adverse decision to occur, the actual cost to the covered person of the service if the final adverse decision is not reversed must exceed $300.

"Emergency Medical Condition" - the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means a health condition or illness that if not treated within the time frame allotted for a standard review will result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy. "Emergency medical condition" also means a health condition that would be terminal without the requested treatment as determined by the person's treating health care provider.

"Expedited Review" - a review of a final adverse decision that is provided in an urgent manner due to the fact that the covered person has an emergency medical condition.

"Final Adverse Decision" - means a utilization review determination: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition after granting an expedited review; or (iii) denying benefits or coverage, and concerning which all internal appeals available to the covered person pursuant to Title 32.1 of the Code of Virginia have been exhausted. In other words, and except in emergency situations, it is the final decision of the plan after the internal appeal process has been exhausted.

"Impartial Health Entity" - an organization selected by the Bureau of Insurance that performs, under contract with the Bureau of Insurance, reviews of final adverse decisions. The Bureau of Insurance is not an impartial health entity.

"Managed Care Health Insurance Plan" or **"MCHIP"** - an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which 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 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.

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APPEAL OF FINAL ADVERSE DECISION FORM

If you meet the definition of an **appellant**[1], and have had a request for approval of health care service(s) denied by a **Managed Care Health Insurance Plan (MCHIP)**, you may have the right to an external review of the **MCHIP's** decision. An **impartial health entity** selected by the Bureau of Insurance will review the appropriateness of the **MCHIP's** decision, and make a recommendation to the Commissioner of Insurance as to whether the health care service(s) should be covered. In order for such a review to occur, the **appellant** must complete and sign this form. Additionally, the appeal in question must meet the following criteria:

1. The **cost of service** in question must exceed $300;
2. The appeal must be filed within 30 days of the **final adverse decision** by the **MCHIP**;
3. The **MCHIP's** internal appeal process must have been exhausted (except for **expedited reviews**); and
4. A $50 filing fee must be submitted with this form by check or money order made payable to the Treasurer of Virginia. This fee may be waived or refunded if it can be demonstrated that paying the fee constitutes a financial hardship to the **covered person** (see item 7 on the following page); and is refundable if the appeal is not accepted for review.

Additional instructions and definitions of key terms for completing this form are attached. If you have questions while completing this form or if you have questions that are not addressed in the instruction form, you may contact The Office of the Managed Care Ombudsman toll free at (877) 310-6560, or locally at (804) 371-9032, for assistance.

The decision reached as a result of this external review process is binding upon the **covered person** as well as the issuer of the **covered person**'s policy to the same extent that each would be bound by a judgment entered in a court action at law or in equity.

I request an external review of the **MCHIP's final adverse decision** by an **impartial health entity** as chosen by the Bureau of Insurance. I certify that the **covered person**'s **MCHIP's** internal appeals have been exhausted, or that the requirements for an **expedited review** have been met.

(Please type or print clearly all requested information in the spaces provided, or use additional pages, if necessary.)

1. Name of the **Covered Person**:_____

   Address:_____

   _____

   City:_____ State:_____ Zip:_____

   Daytime Phone Number(s):_____

   Date of Birth:_____ Sex:_____

   ID# (Policy or Certificate Number):_____

2. If you are an **appellant other than** the **covered person**, please tell us your name and what your relationship is with the **covered person**:_____

   _____

[1] Words in bold type are defined key terms.

3. Complete Name of **MCHIP**:_____

   Address:_____

   _____

   City:_____ State:_____ Zip:_____

   Phone Number:(___)_____

   Is this health coverage provided through an employer? ☐ Yes ☐ No

   If yes, please provide the employer's name, address, and telephone number:_____

   _____

   _____

   _____

4. On a separate sheet of paper, please describe the situation you are seeking help with and describe the service(s) or procedure(s) in question:

   Please send us a copy of the letter informing the **covered person** of the **MCHIP's final adverse decision.**

5. Are you requesting an **expedited review**? ☐ Yes ☐ No

   If yes, please provide documentation that the **covered person**'s situation involves an **emergency medical condition.**

6. **a.** In the opinion of the covered person's health care provider, is the covered person's condition terminal without this treatment? ☐ Yes ☐ No If Yes, continue to **b.** If No, skip to question 7.
   b. Has the requested treatment already been provided? ☐ Yes ☐ No If Yes, skip to question 7. If No, continue to **c.**
   c. Do you plan to delay the treatment requested while awaiting this external appeal decision? ☐ Yes ☐ No

7. Are you requesting a waiver of the $50 filing fee? ☐ Yes ☐ No

   If yes, please provide the reason and documentation to support the claim that paying the $50 filing fee would cause financial hardship to the **covered person.**

8. The estimated total cost of the denied services to the covered person: $_____.

AUTHORIZATION

I understand and agree that a copy of this form and any information I provide may be forwarded to the **MCHIP** and to the **impartial health entity.**

_____ _____

Signature of **Appellant** (if not the **Covered Person**) Date

_____ _____

Signature of **Covered Person** or Other Authorized Signature Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization must be signed by (i) the covered person; (ii) the covered person's parent, legal guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

Any health care provider of services or supplies, insurance company, or any other organization, institution or person that has a record or knowledge regarding the covered person named below and such person's health, is hereby authorized to furnish to the Bureau of Insurance, or its designated impartial health entity, information concerning services or supplies provided or proposed to be provided to such covered person.

If I am not the covered person listed below, I hereby certify that I am authorized by law to execute this authorization on the covered person's behalf.

This authorization is given for the purpose of conducting an external review of a final adverse decision made by a utilization review entity. This authorization is valid for 90 days from the date below.

Printed Name of Covered Person:_____

Social Security # of Covered Person:_____

Covered Person's Date of Birth:_____

Signature of Covered Person:_____

Date:_____

OR

Other Authorized Signature:_____

Date:_____