



General Assembly

January Session, 2011

Raised Bill No. 1082

LCO No. 3534

03534_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING UTILIZATION REVIEW.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-226 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2011*):

3 For purposes of sections 38a-226 to 38a-226d, inclusive, as amended
4 by this act:

5 (1) "Utilization review" means the prospective, [or] concurrent or
6 retrospective assessment of the necessity and appropriateness of the
7 allocation of health care resources and services given or proposed to be
8 given to an individual within this state. [Utilization review shall not
9 include elective requests for clarification of coverage.]

10 (2) "Utilization review company" means any company, organization
11 or other entity performing utilization review, except:

12 (A) An agency of the federal government;

13 (B) An agent acting on behalf of the federal government, but only to
14 the extent that the agent is providing services to the federal
15 government;

16 (C) Any agency of the state of Connecticut; or

17 (D) A hospital's internal quality assurance program except if
18 associated with a health care financing mechanism.

19 (3) "Adverse determination" means a utilization review company's
20 decision that an admission, service, procedure or extension of stay is
21 not medically necessary.

22 ~~[(3)]~~ (4) "Commissioner" means the Insurance Commissioner.

23 (5) "Concurrent determination" means a utilization review
24 company's decision of the medical necessity of an admission, service,
25 procedure or extension of stay while such admission, service,
26 procedure or extension of stay is being provided.

27 ~~[(4)]~~ (6) "Enrollee" means an individual [who has contracted for or]
28 patient who participates in coverage under an insurance policy, a
29 health care center contract, an employee welfare benefits plan, a
30 hospital or medical services plan contract or any other benefit program
31 providing payment, reimbursement or indemnification for health care
32 costs for an individual or his eligible dependents.

33 (7) "Enrollee's representative" means a legal guardian or agent of an
34 enrollee.

35 (8) "Final adjudication" means a utilization review company's
36 decision that is not subject to any further internal appeal.

37 (9) "Medically necessary" or "medical necessity" means health care
38 services that a physician, exercising prudent clinical judgment, would
39 provide to a patient for the purpose of preventing, evaluating,
40 diagnosing or treating an illness, injury, disease or its symptoms, and
41 that are: (A) In accordance with generally accepted standards of
42 medical practice; (B) clinically appropriate, in terms of type, frequency,
43 extent, site and duration and considered effective for the patient's
44 illness, injury or disease; and (C) not primarily for the convenience of

45 the patient, physician or other health care provider and not more
46 costly than an alternative service or sequence of services at least as
47 likely to produce equivalent therapeutic or diagnostic results as to the
48 diagnosis or treatment of that patient's illness, injury or disease. For
49 the purposes of this subdivision, "generally accepted standards of
50 medical practice" means standards that are based on credible scientific
51 evidence published in peer-reviewed medical literature generally
52 recognized by the relevant medical community or otherwise consistent
53 with the standards set forth in policy issues involving clinical
54 judgment.

55 (10) "Prospective determination" means a utilization review
56 company's decision of the medical necessity of an admission, service,
57 procedure or extension of stay to be provided to the enrollee.

58 ~~[(5)]~~ (11) "Provider of record" or "provider" means the physician or
59 other licensed practitioner identified to the utilization review [agent]
60 company as having primary responsibility for the care, treatment and
61 services rendered to an individual.

62 (12) "Retrospective determination" means a utilization review
63 company's decision of the medical necessity of an admission, service,
64 procedure or extension of stay that has been provided to the enrollee.

65 Sec. 2. Subsection (a) of section 38a-226c of the general statutes is
66 repealed and the following is substituted in lieu thereof (*Effective*
67 *October 1, 2011*):

68 (a) All utilization review companies shall meet the following
69 minimum standards:

70 (1) Each utilization review company shall maintain and make
71 available procedures for [providing notification of] its determinations
72 [regarding certification] in accordance with the following:

73 (A) [Notification] (i) Written notification of any prospective,
74 concurrent or retrospective determination by the utilization review

75 company shall be mailed or otherwise communicated to [the provider
76 of record or] the enrollee, [or other appropriate individual within] the
77 enrollee's representative or the provider of record not later than two
78 business days [of] after the receipt of all information necessary to
79 complete the review, [, provided any determination not to certify an
80 admission, service, procedure or extension of stay shall be in writing.]

81 (ii) In addition to providing written notification of a determination,
82 the utilization review company may give authorization orally or
83 through a communication other than in writing. If the determination is
84 an approval for a request, the company shall provide a confirmation
85 number corresponding to the authorization.

86 (B) (i) After a prospective determination that authorizes an
87 admission, service, procedure or extension of stay has been
88 communicated by the utilization review company to the [appropriate
89 individual, based on accurate information from the] enrollee or the
90 enrollee's representative and the enrollee's provider, the utilization
91 review company [may] shall not reverse such determination if such
92 admission, service, procedure or extension of stay has taken place in
93 reliance on such determination, unless the determination was based on
94 inaccurate information from the provider.

95 (ii) Regardless of whether a prospective determination is required
96 by contract, a utilization review company shall provide such
97 prospective determination upon request by an enrollee, an enrollee's
98 representative or an enrollee's provider.

99 [(B) Notification of a concurrent determination shall be mailed or
100 otherwise communicated to the provider of record within two business
101 days of receipt of all information necessary to complete the review or,
102 provided all information necessary to perform the review has been
103 received, prior to the end of the current certified period and provided
104 any determination not to certify an admission, service, procedure or
105 extension of stay shall be in writing.]

106 (C) [The utilization review company shall not make a determination
107 not to certify based on incomplete information unless it has clearly
108 indicated, in writing, to the provider of record or the enrollee all the
109 information that is needed to make such determination.] If an
110 enrollee's provider requests a concurrent determination, the utilization
111 review company shall provide, if requested by such provider, an
112 opportunity for such provider to discuss the request for concurrent
113 determination with the health care professional making the decision.

114 (D) [Notwithstanding subparagraphs (A) to (C), inclusive, of this
115 subdivision, the utilization review company may give authorization
116 orally, electronically or communicated other than in writing. If the
117 determination is an approval for a request, the company shall provide
118 a confirmation number corresponding to the authorization.] If an
119 enrollee, an enrollee's representative or an enrollee's provider requests
120 a prospective or retrospective determination and the utilization review
121 company does not possess all the information necessary to make such
122 determination, the utilization review company shall request from the
123 appropriate individual all such information in writing it requires and
124 shall provide a copy of such request to the enrollee or the enrollee's
125 representative. The utilization review company shall maintain a record
126 of all such requests for additional information. The utilization review
127 company shall not issue any notification declining certification or
128 authorization of an admission, service, procedure or extension of stay
129 prior to receiving and evaluating the requested information, and shall
130 not render a determination based on a lack of necessary information
131 without having first issued a written request for additional
132 information and providing a reasonable opportunity to comply with
133 such request.

134 (E) [Except as provided in subparagraph (F) of this subdivision with
135 respect to a final notice, each] Each notice of a determination not to
136 certify or authorize an admission, service, procedure or extension of
137 stay shall include in writing (i) the principal reasons for the
138 determination, (ii) the procedures to initiate an appeal of the

139 determination or the name and telephone number of the person to
140 contact with regard to an appeal pursuant to the provisions of this
141 section, or a statement that all applicable internal appeals have been
142 exhausted, and (iii) the procedure to appeal to the commissioner
143 pursuant to section 38a-478n, as amended by this act.

144 (F) [Each notice of a final determination not to certify an admission,
145 service, procedure or extension of stay shall include in writing (i) the
146 principal reasons for the determination, (ii) a statement that all internal
147 appeal mechanisms have been exhausted, and (iii) a copy of the
148 application and procedures prescribed by the commissioner for filing
149 an appeal to the commissioner pursuant to section 38a-478n.] Any
150 adverse determination shall be made by a licensed health care
151 professional. Except for final adjudications as set forth in
152 subparagraph (F) of subdivision (2) of this subsection, physicians,
153 nurses and other licensed health care professionals making utilization
154 review decisions shall have current licenses from a state licensing
155 agency in the United States or appropriate certification from a
156 recognized accreditation agency in the United States.

157 (2) Each utilization review company shall maintain and make
158 available a written description of the [appeal procedure] utilization
159 review company's procedures for appeals by which [either] the
160 enrollee, the enrollee's representative or the provider of record may
161 seek review of determinations not to certify or authorize an admission,
162 service, procedure or extension of stay. [An appeal by the provider of
163 record shall be deemed to be made on behalf of the enrollee and with
164 the consent of such enrollee if the admission, service, procedure or
165 extension of stay has not yet been provided or if such determination
166 not to certify creates a financial liability to the enrollee.] The
167 procedures for appeals shall include the following:

168 (A) Each utilization review company shall notify in writing the
169 enrollee or the enrollee's representative and provider of record of its
170 [determination on] adjudication of the appeal as soon as practical, but

171 in no case later than [thirty] fifteen days after receiving the required
172 documentation on the appeal.

173 (B) On appeal, all determinations not to certify or authorize an
174 admission, service, procedure or extension of stay shall be made by a
175 licensed practitioner of the healing arts who has a current license from
176 a state licensing agency in the United States or appropriate certification
177 from a recognized accreditation agency in the United States.

178 (C) An appeal filed by an enrollee's provider shall not preclude such
179 enrollee or enrollee's representative from filing a separate appeal of the
180 same determination.

181 [(3)] (D) The process established by each utilization review
182 company [may] shall include a reasonable period within which an
183 appeal [must be filed to be considered] shall be filed, provided such
184 period is not less than ninety days after the issuance of the
185 determination. Any such period may be extended by the utilization
186 review company upon a showing of a justifiable reason for the
187 enrollee's failure or inability to request an appeal in a timely fashion,
188 including, but not limited to, illness, incapacity, hospitalization or
189 failure to receive the determination within the time period set forth in
190 this section.

191 [(4)] (E) Each utilization review company shall also provide for an
192 expedited appeals process for emergency or [life threatening] life-
193 threatening situations, as determined by the enrollee's provider. Each
194 utilization review company shall complete the adjudication of such
195 expedited appeals [within two] not later than one business [days of]
196 day after the date the appeal is filed and all information necessary to
197 complete the appeal is received by the utilization review company. If
198 the utilization review company does not possess all information
199 necessary to complete the appeal, the utilization review company shall
200 request from the appropriate individual all such information in writing
201 it requires and shall provide a copy of such request to the enrollee or
202 the enrollee's representative. The utilization review company shall

203 maintain a record of all such requests for additional information. The
204 utilization review company shall not render an adjudication based on
205 a lack of necessary information without first having issued a written
206 request for additional information and providing a reasonable
207 opportunity to comply with such request.

208 (F) (i) If the appeal is for a final adjudication, the utilization review
209 company shall, at its expense, have the case reviewed by a physician
210 who is a specialist in the same specialty or subspecialty as the provider
211 of the requested treatment. Except as set forth in subparagraph (E) of
212 this subdivision, such review shall be completed not later than thirty
213 days after the date such review was requested by the utilization review
214 company. The reviewing physician shall issue a written report of the
215 findings to the utilization review company, which shall maintain
216 documentation of such review for the commissioner's verification,
217 including the name of such reviewing physician.

218 (ii) Except for a claim brought pursuant to chapter 568, a final
219 adjudication that upholds an adverse determination shall have been
220 made by a physician, nurse or other licensed health care professional
221 who is under the authority of a physician, nurse or other licensed
222 health care professional who holds a current Connecticut license from
223 the Department of Public Health.

224 (iii) Upon request by an enrollee, an enrollee's representative or an
225 enrollee's provider, the utilization review company shall provide a
226 hearing prior to the final adjudication of an appeal. Such hearing may
227 be conducted in person, by telephone or by other means at the
228 enrollee's discretion.

229 (I) The enrollee, the enrollee's representative, the enrollee's provider
230 and such other persons as requested by the enrollee may participate in
231 such hearing.

232 (II) The reviewing physician specified in subparagraph (F)(i) of this
233 subdivision shall participate in such hearing.

234 (III) Voting members of the utilization review company's review
235 panel shall participate in such hearing and in the deliberations on the
236 final adjudication.

237 (IV) No other person shall participate in such hearing or
238 deliberations unless approved by the enrollee or the enrollee's
239 representative and the utilization review company.

240 (iv) The utilization review company shall prepare a video or audio
241 recording of such hearing and shall provide a copy of such recording
242 to the enrollee or the enrollee's representative and the enrollee's
243 provider if such enrollee, enrollee's representative or enrollee's
244 provider appeals the final adjudication to the commissioner pursuant
245 to section 38a-478n, as amended by this act.

246 (G) If an adjudication upholds a determination not to certify or
247 authorize an admission, service, procedure or extension of stay, the
248 utilization review company shall notify the enrollee or the enrollee's
249 representative and the enrollee's provider in writing of such
250 adjudication. Such notification shall include: (i) The principal reasons
251 for the adjudication, provided in the case of an adverse determination,
252 the utilization review company shall include the specific reasons why
253 the admission, service, procedure or extension of stay is not medically
254 necessary, along with a summary of all information relied upon in
255 making such a finding; (ii) the procedures to initiate an appeal of such
256 adjudication or the name and telephone number of the person to
257 contact with regard to an appeal pursuant to the provisions of this
258 section; and (iii) in the case of a final adjudication, the procedure to
259 appeal to the commissioner pursuant to section 38a-478n, as amended
260 by this act.

261 [(5)] (3) Each utilization review company shall utilize written
262 clinical criteria and review procedures [which] that are established and
263 periodically evaluated and updated with appropriate involvement
264 from practitioners. Such criteria and procedures shall be consistent
265 with the definition of "medical necessity" set forth in section 38a-226,

266 as amended by this act, and such definition shall control in the event of
267 a conflict.

268 [(6) Physicians, nurses and other licensed health professionals
269 making utilization review decisions shall have current licenses from a
270 state licensing agency in the United States or appropriate certification
271 from a recognized accreditation agency in the United States, provided,
272 any final determination not to certify an admission, service, procedure
273 or extension of stay for an enrollee within this state, except for a claim
274 brought pursuant to chapter 568, shall be made by a physician, nurse
275 or other licensed health professional under the authority of a
276 physician, nurse or other licensed health professional who has a
277 current Connecticut license from the Department of Public Health.

278 (7) In cases where an appeal to reverse a determination not to certify
279 is unsuccessful, each utilization review company shall assure that a
280 practitioner in a specialty related to the condition is reasonably
281 available to review the case. When the reason for the determination not
282 to certify is based on medical necessity, including whether a treatment
283 is experimental or investigational, each utilization review company
284 shall have the case reviewed by a physician who is a specialist in the
285 field related to the condition that is the subject of the appeal. Any such
286 review, except for a claim brought pursuant to chapter 568, that
287 upholds a final determination not to certify in the case of an enrollee
288 within this state shall be conducted by such practitioner or physician
289 under the authority of a practitioner or physician who has a current
290 Connecticut license from the Department of Public Health. The review
291 shall be completed within thirty days of the request for review. The
292 utilization review company shall be financially responsible for the
293 review and shall maintain, for the commissioner's verification,
294 documentation of the review, including the name of the reviewing
295 physician.]

296 [(8)] (4) Except as provided in subsection (e) of this section, each
297 utilization review company shall make review staff available by toll-

298 free telephone, at least forty hours per week during normal business
299 hours.

300 [(9)] (5) Each utilization review company shall comply with all
301 applicable federal and state laws to protect the confidentiality of
302 individual medical records. Summary and aggregate data shall not be
303 considered confidential if [it does] they do not provide sufficient
304 information to allow identification of individual patients.

305 [(10)] (6) Each utilization review company shall allow a minimum of
306 twenty-four hours following an emergency admission, service or
307 procedure for an enrollee or his representative to notify the utilization
308 review company and request certification or continuing treatment for
309 that condition.

310 [(11)] (7) No utilization review company [may] shall give an
311 employee any financial incentive based on the number of denials of
312 certification such employee makes.

313 [(12)] (8) Each utilization review company shall annually file with
314 the commissioner:

315 (A) The names of all managed care organizations, as defined in
316 section 38a-478, that the utilization review company services in
317 Connecticut;

318 (B) Any utilization review services for which the utilization review
319 company has contracted out for services and the name of such
320 company providing the services;

321 (C) The number of utilization review determinations not to certify
322 or authorize an admission, service, procedure or extension of stay and
323 the outcome of such determination upon appeal within the utilization
324 review company. Determinations related to mental or nervous
325 conditions, as defined in section 38a-514, shall be reported separately
326 from all other determinations reported under this subdivision; and

327 (D) The following information relative to requests for utilization
328 review of mental health services for enrollees of fully insured health
329 benefit plans or self-insured or self-funded employee health benefit
330 plans, separately and by category: (i) The reason for the request,
331 including, but not limited to, an inpatient admission, service,
332 procedure or extension of inpatient stay or an outpatient treatment, (ii)
333 the number of requests denied by type of request, and (iii) whether the
334 request was denied or partially denied.

335 [(13) Any utilization review decision to initially deny services shall
336 be made by a licensed health professional.]

337 Sec. 3. Subsection (c) of section 38a-226c of the general statutes is
338 repealed and the following is substituted in lieu thereof (*Effective*
339 *October 1, 2011*):

340 (c) The provider of record shall provide to each utilization review
341 company, within a reasonable period of time, all relevant information
342 necessary for the utilization review company to certify or authorize the
343 admission, procedure, treatment or length of stay. Failure of the
344 provider to provide such documentation for review shall be grounds
345 for a denial of certification or authorization in accordance with the
346 policy of the utilization review company or the health benefit plan.

347 Sec. 4. Subsection (m) of section 38a-479aa of the general statutes is
348 repealed and the following is substituted in lieu thereof (*Effective*
349 *October 1, 2011*):

350 (m) Each utilization review determination made by or on behalf of a
351 preferred provider network shall be made in accordance with sections
352 38a-226 to 38a-226d, inclusive, [except that any] as amended by this
353 act. Any initial appeal of a determination not to certify or authorize an
354 admission, service, procedure or extension of stay shall be conducted
355 in accordance with subdivision [(7)] (2) of subsection (a) of section 38a-
356 226c, as amended by this act, and any subsequent appeal shall be
357 referred to the managed care organization on whose behalf the

358 preferred provider network provides services. The managed care
359 organization shall conduct the subsequent appeal in accordance with
360 said subdivision.

361 Sec. 5. Subdivision (12) of subsection (d) of section 38a-479bb of the
362 general statutes is repealed and the following is substituted in lieu
363 thereof (*Effective October 1, 2011*):

364 (12) A provision that the preferred provider network shall ensure
365 that utilization review determinations are made in accordance with
366 sections 38a-226 to 38a-226d, inclusive, [except that any] as amended
367 by this act. Any initial appeal of a determination not to certify or
368 authorize an admission, service, procedure or extension of stay shall be
369 made in accordance with subdivision [(7)] (2) of subsection (a) of
370 section 38a-226c, as amended by this act. In cases where an appeal to
371 reverse a determination not to certify or authorize is unsuccessful, the
372 preferred provider network shall refer the case to the managed care
373 organization which shall conduct the subsequent appeal, if any, in
374 accordance with said subdivision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2011</i>	38a-226
Sec. 2	<i>October 1, 2011</i>	38a-226c(a)
Sec. 3	<i>October 1, 2011</i>	38a-226c(c)
Sec. 4	<i>October 1, 2011</i>	38a-479aa(m)
Sec. 5	<i>October 1, 2011</i>	38a-479bb(d)(12)

Statement of Purpose:

To clarify the requirements and standards for utilization review companies and the reviews such companies perform.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]