H-3858.3

HOUSE BILL 2848

State of Washington 54th Legislature 1996 Regular Session

By Representatives Dyer, Backlund and Casada

Read first time 01/23/96. Referred to Committee on Health Care.

1 AN ACT Relating to utilization review activities; adding new
2 sections to chapter 48.44 RCW; and creating a new section.

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

4 NEW SECTION. **Sec. 1.** It is the intent of sections 2 and 3 of this
5 act to define standards for utilization review of health care services
6 and to promote the delivery of health care in a cost-effective manner,
7 as well as to encourage the availability of effective and consistent
8 utilization review throughout this state.

9 NEW SECTION. **Sec. 2.** Unless the context clearly requires
10 otherwise, the definitions in this section apply throughout section 3
11 of this act.
12 (1) "Appeal" means a formal request, either orally or in writing,
13 to reconsider a determination not to certify an admission, extension of
14 stay, or other health care service.
15 (2) "Adverse determination" means a decision by a review
16 organization not to certify an admission, service, procedure, or
17 extension of stay.

1 (3) "Certification" means a determination by a utilization review
2 organization that an admission, extension of stay, or other health care
3 service has been reviewed and, based on the information provided, meets
4 the clinical requirements for medical necessity, appropriateness, level
5 of care, or effectiveness under the auspices of the applicable health
6 benefit plan.
7 (4) "Review organization" means a person or entity performing
8 utilization review that is either employed by, affiliated with, under
9 contract with, or acting on behalf of:
10 (a) A business entity doing business in this state; or
11 (b) A party that provides or administers health care benefits to
12 citizens of this state, including a disability insurer, a health care
13 service contractor, a health maintenance organization authorized to
14 offer health insurance policies or contracts or pay for the delivery of
15 health care services or treatment in this state, or a designee of one
16 of these parties.
17 (5) "Utilization review" means the prospective, concurrent, or
18 retrospective assessment of the necessity and appropriateness of the
19 allocation of health care resources and services of a provider or
20 facility, given or proposed to be given to a patient or group of
21 patients. Utilization review does not mean elective requests for
22 clarification of coverage or medical claims review.

23 NEW SECTION. **Sec. 3.** (1) Beginning July 1, 1996, every review
24 organization that proposes to provide coverage of inpatient hospital
25 and medical benefits and outpatient surgical benefits for residents of
26 this state with utilization review of those benefits must meet the
27 following standards:
28 (a) Review organizations must comply with all applicable state and
29 federal laws to protect confidentiality of enrollee medical records;
30 (b) Notification of a determination to certify by the review
31 organization must be mailed or otherwise communicated either to the
32 provider of record or the enrollee, or both the provider of record and
33 the enrollee, or other appropriate individual, within two business days
34 of the determination, which is based on the receipt of all information
35 necessary to complete the review;
36 (c) Review organizations must maintain a written description of the
37 appeal procedure by which enrollees or the provider of record may seek

1 review of determinations by the review organization. The appeal
2 procedure must provide for the following:

3 (i) On appeal, all determinations to deny an admission, service, or
4 procedure as being necessary or appropriate must be made by an
5 individual in a licensed physician category who is familiar with the
6 treatment of the medical condition, procedure, or treatment under
7 discussion and is reasonably available as appropriate to review the
8 case, other than the physician or licensed medical professional who
9 made the initial determination;

10 (ii) Review organizations must complete the adjudication of appeals
11 of determinations not to certify admissions, services, and procedures
12 no later than thirty days from the date the appeal is filed and all
13 information necessary to complete the appeal is received; and

14 (iii) Review organizations must also provide for an expedited
15 appeals process for emergency or life-threatening situations. Review
16 organizations must complete the adjudication of the expedited appeals
17 within two business days of the date the appeal is filed, and the
18 receipt of all information necessary to complete the appeal;

19 (d) Review organizations must make staff available by toll-free
20 telephone, at least forty hours per week during normal business hours;

21 (e) Review organizations must have a phone system capable of either
22 accepting or recording, or both accepting and recording, incoming phone
23 calls during other than normal business hours, and must respond to
24 these calls within two business days; and

25 (f) Review organizations must allow a minimum of forty-eight hours
26 following an emergency admission, service, or procedure for an enrollee
27 or his or her representative to notify the review organization and
28 request certification or continuing treatment for that condition. A
29 review organization must permit immediate hospitalization of an
30 enrollee for whom the physician of record determines the admission to
31 be of a life-threatening emergency, so long as medical necessity is
32 promptly documented. Nothing in this section requires the review
33 organization or another party to authorize payment for services
34 provided during that forty-eight hour period, regardless of medical
35 necessity, if those services do not otherwise constitute covered
36 benefits.

37 (2) A determination to deny a review organization to the necessity
38 or appropriateness of an admission, service, or procedure must be
39 reviewed by a physician or a licensed medical professional making a

1 determination in accordance with standards or guidelines approved by a
2 physician. A determination not to certify an admission, service, or
3 procedure must be made by a licensed physician.
4 (3) A notification of a determination not to certify an admission,
5 service, or procedure must include:
6 (a) The principal reason for the determination; and
7 (b) The procedures to initiate an appeal of the determination.
8 (4) Hospitals and physicians must cooperate with the reasonable
9 efforts of review organizations to ensure that all necessary patient
10 information is available in a timely fashion by phone during normal
11 business hours. Procedures must be established by hospitals and
12 physicians to allow on-site review of medical records by review
13 organizations.
14 (5) A review organization that has received accreditation by a
15 nationally recognized accreditation organization or an organization
16 accredited by the department of health for the purposes of chapter
17 . . ., Laws of 1996 (this act).

18 NEW SECTION. **Sec. 4.** Sections 2 and 3 of this act are each added
19 to chapter 48.44 RCW.

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