

RULES AND REGULATIONS
FOR THE UTILIZATION REVIEW
OF HEALTH CARE SERVICES
(R23-17.12-UR)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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INTRODUCTION

These *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12-UR)* are promulgated pursuant to the authority conferred under Chapters 23-17.12 and 42-35 of the General Laws of Rhode Island, as amended, and are established for the purpose of defining minimum standards for the utilization review of health care services, and the delivery of health care in a cost effective manner.

In accordance with the provisions of section 42-35-3 (c) of the General Laws of Rhode Island, as amended, in the development of the regulations, consideration was given to: (1) alternative approaches to the regulations; and (2) duplication or overlap with other state regulations. Based on the available information, no known alternative approach, duplication or overlap was identified.

These amended regulations shall supersede all previous *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12-UR)* promulgated by the Department of Health and filed with the Secretary of State.

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Section 1.0 *Definitions*

Wherever used in these rules and regulations, the terms listed below shall be construed as follows:

- 1.1 **"Act"** means Chapter 23-17.12 of the Rhode Island General Laws, as amended.
- 1.2 **"Adverse determination"** means a utilization review decision by a review agent not to authorize a health care service. A decision by a review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse determinations include decisions not to authorize formulary and nonformulary medication.
- 1.3 **"Appeal"** means a subsequent review of an adverse determination upon request by a patient or provider to reconsider all or part of the original decision.
- 1.4 **"Attending provider"** shall mean the same as **"ordering practitioner"** for the purposes of the rules and regulations herein.
- 1.5 **"Authorization"** means the review agent's utilization review, performed according to section 1.34, concluded that the allocation of health care services of a provider, given or proposed to be given to a patient was approved or authorized.
- 1.6 **"Benefit determination"** means a decision of the enrollee's entitlement to payment for covered health care services as defined in an agreement with the payor or its delegate.
- 1.7 **"Business day"** means a day during which the state government of Rhode Island conducts regular business.
- 1.8 **"Certificate"** means a certificate of registration granted by the director to a review agent.
- 1.9 **"Complaint"** means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.
- 1.10 **"Concurrent assessment"** means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. This review does not mean the elective requests for clarification of coverage or claims review or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.
- 1.11 **"Conflict of interest"** means the lack of objectivity which may be caused by, but is not limited to, financial incentives which base reimbursements received upon the numbers of adverse determinations rendered, or other action which prevents the proper discharge of duties between a reviewer and other affected persons.
- 1.12 **"Department"** means the Rhode Island Department of Health.

- 1.13 ***“Designee*** means a qualified professional responsible for the treatment of the patient in the absence of the attending provider. The designee is selected and assigned to the patient by the attending provider.
- 1.14 ***“Director”*** means the Director of the Department of Health.
- 1.15 ***“Emergent health care services”*** has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to Chapter 42-12.3 of the Rhode Island General Laws, as amended, as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.
- 1.16 ***“Expedited appeal”*** means a request to reconsider an adverse determination, for a prospective or concurrent emergent health care service.
- 1.17 ***“External appeals agency”*** means an unrelated and objective appeal agency, selected by the Director, to provide a binding decision in cases where a second level appeal by a certified utilization review agency or review agent has been unsuccessful.
- 1.18 ***“Health care services”*** means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other services, activities, or supplies that are covered by the patient's benefit plan.
- 1.19 ***“Material modification”*** means any substantial systemic change to the certification information on file at the Department, which is deemed material by the Department pursuant to section 2.6 herein.
- 1.20 ***“Ordering practitioner”*** means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, chiropractor, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist who has been identified by the patient/family as having a significant role in the determination and delivery of the individual's medical care and who has requested the admission, health care service, procedure or extension of stay.
- 1.21 ***“Patient”*** means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.
- 1.22 ***“Payor”*** means a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state.

- 1.23 **"Person"** means any individual, trust or estate, partnership, corporation (including but not limited to associations, joint stock companies), limited liability companies, state or political subdivision or instrumentality of the state.
- 1.24 **"Practitioner"** means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist.
- 1.25 **"Precertification"** is the requirement that a patient or provider, as a condition of coverage for a specific benefit, obtain approval from a review agent prior to services being provided. This shall have the same meaning as preauthorization and prior authorization.
- 1.26 **"Prospective assessment"** means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.
- 1.27 **"Provider"** means any health care facility, as defined in section 23-17-2 of the Rhode Island General Laws, as amended, including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.
- 1.28 **"Provider of record"** shall mean the same as "provider" for the purposes of the rules and regulations herein.
- 1.29 **"Retrospective assessment"** means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.
- 1.30 **"Review agent" or "review agency"** means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:
- 1.30.1 A business entity doing business in this state;
- 1.30.2 A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, non-profit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or
- 1.30.3 A provider.
- 1.31 **"Same or similar specialty"** means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.
- 1.32 **"Therapeutic interchange"** means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that

can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

- 1.33 ***"Urgent health care services"*** has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to Chapter 12.3 of title 42 of the Rhode Island General Laws, as amended, as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance abuse or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in section 1.15 herein.
- 1.34 ***"Utilization review"*** means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient. Utilization review does not include:
- 1.34.1 Elective requests for the clarification of coverage; or
 - 1.34.2 Benefit determination; or
 - 1.34.3 Claims review that does not include the assessment of the medical necessity and appropriateness; or
 - 1.34.4 A provider's internal quality assurance program except if it is associated with a health care financing mechanism; or
 - 1.34.5 The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or
 - 1.34.6 The assessment by a pharmacist licensed pursuant to the provisions of Chapter 19 of Title 5 of the Rhode Island General Laws, as amended, and practicing in a pharmacy operating as part of a licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.
- 1.35 ***"Utilization review plan"*** means a description of the standards governing utilization review activities performed by a private review agent.

Section 2.0 *General Requirements*

- 2.1 A review agent shall not conduct utilization review for health care services delivered or proposed to be delivered in the state of Rhode Island unless the Department has granted the review agent a certificate.
- 2.2 Individuals shall not be required to hold separate certification under the Act when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.
- 2.3 A certificate issued under the Act is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer. Such transfer requires a new application for certification.
- 2.4 A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two (2) year term as provided in the Act.
 - 2.4.1 An application for re-certification shall be submitted sixty (60) days prior to the expiration of the certificate or waiver.
 - a) If a completed application for re-certification is being processed by the Department, a certificate may be continued until a renewal determination is made.
- 2.5 The cost of the application process, certification, re-certification, material modifications, agency reviews, and other activities directly related to obtaining and maintaining a utilization review agency's certification including, but not limited to, compliance with the rules and regulations herein shall be borne by the review agency.
 - 2.5.1 An application fee of five hundred dollars (\$500) shall accompany an application for certification and re-certification. The cost of one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the Department for the certification activities described in section 2.5 herein shall be paid by the agency. Such cost shall be in addition to the application fee and any other fee, fine or tax otherwise payable to the Department as a result of the enforcement of the rules and regulations herein.
 - 2.5.2 Certified utilization review agencies shall have the opportunity to review documents to substantiate their costs as described in section 2.5.1 herein.
 - 2.5.3 Payments for the costs of the application process, certification, re-certification, material modifications and agency reviews shall be made payable to the General Treasurer, State of Rhode Island.
 - a) Payments shall be billed monthly and payment by the review agency is due thirty (30) days following issuance of each bill.

- b) Failure to make payment by the required due date will result in a fine determined by the Director. Failure to respond to the Department and remit fine within a ninety (90) day period will be subject to section 10.0 herein.
- 2.6 The certified utilization review agency shall notify the Department prior to the implementation of any substantial systemic change in operations relative to the certification information on file with the Department. If the Department determines a change to be material, the certified utilization review agency shall submit an application for a material modification.
 - 2.6.1 The information shall be filed no less than thirty (30) days prior to implementation of the change.
 - 2.6.2 No implementation of any material modification shall be in effect without the prior approval of the Department.
- 2.7 The Department may, in response to a complaint that is provided in written form to the review agent, review an appeal regarding any adverse determination, and may request information of the review agent, provider or patient regarding the status, outcome or rationale regarding the decision.
- 2.8 The Department may review a certified review agency at any time.
 - 2.8.1 Upon the Department's issuance of statements of deficiencies, a plan to correct all deficiencies shall be submitted to the Department by the agency within a twenty (20) calendar day period. If said plan is not acceptable to the Department, the Department may take action in accordance with section 10.0 herein.
- 2.9 A certified utilization review agent shall adhere to any and all applicable state or federal laws.
- 2.10 A review agent is only entitled to review information or data relevant to the utilization review process. A review agent may not disclose or publish individual medical records or any confidential medical information obtained in the performance of utilization review activities. A review agent shall be considered a third party health insurer for the purposes of section 5-37.3-6(b)(6) of the Rhode Island General Laws, as amended, of this state and shall be required to maintain the security procedures mandated in section 5-37.3-4(c) of the Rhode Island General Laws, as amended.
- 2.11 Notwithstanding any other provision of law, the review agent, and all other parties privy to information which is the subject of the Act shall comply with all state and federal confidentiality laws, including, but not limited to, Chapter 5-37.3 of the Rhode Island General Laws, as amended, (Confidentiality of Health Care Communications and Information Act) and specifically section 5-37.3-4(c), which requires limitation on the distribution of information which is the subject of the Act on a "need to know" basis, and section 40.1-5-26 of the Rhode Island General Laws, as amended.

Section 3.0 *Application Requirements for the Certification of Utilization Review Agencies*

- 3.1 An applicant requesting certification or re-certification shall:
 - 3.1.1 Submit a signed and notarized application form provided by the Director, accompanied by supporting documentation that the Director requires; and
 - 3.1.2 Pay the application fee.
- 3.2 An application for certification or re-certification shall be accompanied by the following supporting documentation:
 - 3.2.1 A request that the Department regard specific portions of the standards and criteria or the entire document to constitute "trade secrets" within the meaning of that term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws, as amended;
 - 3.2.2 A list of the third party payors and business entities for which the review agent is performing utilization review in this state and a brief description of the services it is providing for each client;
 - 3.2.3 Evidence of liability insurance or of assets sufficient to cover potential liability;
 - 3.2.4 The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that the delegated agency is a certified utilization review agency delegated to perform utilization review pursuant to all of the requirements of the Act;
 - 3.2.5 The requirement that the review agency shall monitor and evaluate the implementation of its policies on an annual basis;
 - 3.2.6 An adverse determination and internal appeals process consistent with sections 4.0, 5.0, and 6.0, and acceptable to the Department, whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent;
 - 3.2.7 A complaint resolution process consistent with section 1.9 and acceptable to the Department, whereby patients, their physicians, or other health care providers may seek resolution of complaints and other matters of which the review agent has received written notice;
 - 3.2.8 The type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a practitioner with the same licensure status as the ordering practitioner, or a licensed physician or dentist, is permitted to make a prospective or concurrent adverse determination;
 - 3.2.9 The requirement that a representative of the review agent is reasonably accessible to patients, patient's family and providers at least five (5) days a week during

normal business in Rhode Island and during the hours of the agency's review operations;

- 3.2.10 The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
- 3.2.11 The policies and procedures regarding the notification and conduct of patient interviews by the review agent:
 - a) The agency review staff shall notify provider operations staff prior to conducting onsite reviews and/or patient interviews;
 - b) The agency review staff shall identify themselves by name and by the name of the review agency and when conducting onsite reviews, shall display, at all times, picture identification on the utilization review agency's company identification card;
 - c) Patient interviews shall not unreasonably disrupt provider operations, patient care, or patient privacy;
 - d) Clear documentation of the patient interview shall be maintained by the review agency; and
 - e) Utilization review agencies shall not conduct patient interviews for inpatient mental health and substance abuse services.
- 3.2.12 The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient;
- 3.2.13 The requirement that no employee of, or other individual rendering an adverse determination for, a review agent may receive any financial incentives based upon the number of denials of certification made by that employee or individual;
- 3.2.14 Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based upon a reduction of services or the charges for those services, the reduction of length of stay, or utilization of alternative treatment settings; provided, nothing in this chapter shall prohibit capitation agreements and similar arrangements with providers;
- 3.2.15 A copy of the materials used to inform enrollees of the requirements under the health benefit plan for seeking utilization review or pre-certification and their rights under the Act, including information on appealing adverse determinations;
- 3.2.16 A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

- 3.2.17 The requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of the standards, procedures and methods to be used in evaluating proposed or delivered health care services;
- 3.2.18 assurance that the decision to provide treatment or service to a patient is the responsibility of the attending provider and his or her patient;
- 3.2.19 provisions that the determination of covered services and benefits is the responsibility of the payor;
- 3.2.20 The requirement that each review agent shall utilize and provide upon request, by Rhode Island licensed hospitals and the Rhode Island Medical Society, in either electronic or paper format, written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate consultation with Rhode Island licensed physicians, hospitals, including practicing physicians, and other health care providers in the same specialty as would typically treat the services subject to the criteria as follows:
- a) Utilization review agents shall consult with no fewer than five (5) Rhode Island licensed physicians or other health care providers. Further, in instances where the screening criteria and review procedures are applicable to inpatients and/or outpatients of hospitals, the medical director of each licensed hospital in Rhode Island shall also be consulted. Utilization review agents who utilize screening criteria and review procedures provided by another entity may satisfy the requirements of this section if the utilization review agent demonstrates to the satisfaction of the director that the entity furnishing the screening criteria and review procedures has complied with the requirements of this section.
 - b) allowance of at least a thirty (30) day period for the consulting parties to provide written comments and/or recommendations;
 - c) Utilization review agents seeking initial certification shall conduct the consultation for all screening and review criteria to be utilized. Utilization review agents who have been certified for one year or longer shall be required to conduct the consultation on a periodic basis for the utilization review agent's highest volume services subject to utilization review during the prior year; services subject to the highest volume of adverse determinations during the prior year; and for any additional services identified by the Director.
 - d) Utilization review agents shall not include in the consultations as required under section 3.2.20 a), any physicians or other health services providers who have financial relationships with the utilization review agent other than financial relationships for provisions of direct patient care to utilization review agent enrollees and reasonable compensation for consultation as required by section 3.2.20 a).
 - e) All documentation regarding required consultations, including comments and/or recommendations provided by the health care providers involved in the review

of the screening criteria, as well as the utilization review agent's action plan or comments on any recommendations, shall be in writing and shall be furnished to the Department on request. The documentation shall also be provided on request to any licensed health care provider at a nominal cost that is sufficient to cover the utilization review agent's reasonable costs of copying and mailing.

- f) Utilization review agents may utilize non-Rhode Island licensed physicians or other health care providers to provide the consultation as required under section 3.2.20 a), when the utilization review agent can demonstrate to the satisfaction of the Director that the related services are not currently provided in Rhode Island or that another substantial reason requires such approach.
 - g) Utilization review agents whose annualized data reported to the Department demonstrate that the utilization review agent will review fewer than five hundred (500) requests for authorization may request a variance from the requirements of this section.
- 3.2.21 A Memorandum of Understanding approved by the Department signed by the external appeals agency and the certified review agent; and
- 3.2.22 other information requested by the Department to evidence compliance with the rules and regulations herein.

Section 4.0 ***Review Agency Requirements for Adverse Determinations and Internal Appeals***

- 4.1 A review agency must maintain and provide evidence of and adherence to operational policies and procedures for utilization review determinations, which have been approved by the Department and shall include policies and procedures for the following:
- 4.1.1 The clear documentation of the ordering providers' original requests and any negotiation/agreement to accept an alternative treatment or modified extension of stay;
 - 4.1.2 Assurance that the negotiation/agreement between the review agency and the ordering provider is not coerced by the review agency or its reviewers;
 - 4.1.3 Provisions that if a patient or provider does not release the necessary information to the utilization review agency in accordance with sections 2.10 and 2.11 herein, the utilization review agency may deny certification administratively;
 - 4.1.4 If the review agency is unable to make a decision, due to insufficient information, the review agency shall notify the patient and the provider of specific information required to complete the review within the required notification timeframes defined in sections 5.0 and 6.0.
- a) The review agency may allow a fifteen (15) day extension for receipt of the necessary information for non urgent cases and seventy-two (72) hour extension for urgent and emergent cases.

- 4.1.5 A utilization review agency shall not retrospectively deny authorization for health care services provided to a covered person when an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information material to the review or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval granted by the review agent.
- 4.1.6 The requirement that, upon written request made by, or on behalf of a patient, any adverse determination and/or appeal shall include the written evaluation and findings of the reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent.
- 4.1.7 The review agency must conform to the following requirements when making adverse determinations:
- a) The review agent must assure that the licensed practitioner or licensed physician is reasonably available to review the case as required under section 6.1.5 and shall conform to the following:
 - i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or patients;
 - ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer;
 - iii) Agency peer reviewers shall respond to the provider's request for a two-way direct communication provided for in section 6.1.5 d) as follows:
 - A) For a prospective review of non-urgent and non-emergent health care services, a response within one (1) business day of the request for a peer discussion;
 - B) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and
 - C) For retrospective reviews, prior to the first level appeal decision.
 - iv) The review agency will have met the requirements of a two-way direct communication, when requested and/or as required prior to the first level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly.

- A) Such two-way direct communication may include telephone conversations and/or facsimile or electronic transmissions, if mutually agreed upon.
 - v) Repeated violations of this section shall be deemed to be substantial violations pursuant to section 11.0 and shall be cause for the imposition of penalties under that section.
- 4.1.8 No reviewer at any level shall be compensated or paid a bonus or incentive based on making or upholding an adverse determination.
- 4.1.9 No reviewer who has been involved in prior reviews of the case under appeal or who has participated in the direct care of the patient may participate as the sole reviewer in reviewing a case under appeal; provided, however, that when new information has been made available at the first level of appeal, then the review may be conducted by the same reviewer who made the initial adverse determination.
- 4.2 Any notice of an adverse determination shall include:
- 4.2.1 The principal reasons for the adverse determination to include explicit documentation of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in making the adverse determination. The criteria shall be in accordance with the agency criteria noted in section 3.2.20 and shall be made available within the first level appeal timeframe if requested unless otherwise provided as part of the adverse determination notification process;
 - 4.2.2 The procedures to initiate an appeal of the adverse determination, including the name and telephone number of the person to contact with regard to an appeal and a reasonable period of time to request an appeal;
 - 4.2.3 The necessary contact information to complete the two-way direct communication provided for in section 6.1.5; and
 - 4.2.4 The information noted in sections 4.2.1, 4.2.2, and 4.2.3 for all verbal notifications followed by written notification to the patient and provider(s).

Section 5.0 ***Initial Adverse Determination Process***

- 5.1 The review agency shall maintain an adverse determination process which shall meet the following standards:
- 5.1.1 All initial, prospective and concurrent adverse determinations and retrospective adverse determinations for emergent health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or dentist.

- a) This does not prohibit appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and treatment options. Such a discussion shall not constitute an adverse determination, provided though, that any change to the provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the patient.
 - i) Prior to such discussions regarding alternative service and treatment options, the certified review agent must obtain written documentation from the attending provider, or designee, that specifies the name and title of the personnel authorized to conduct such discussion. The review agent also shall provide written documentation to the attending provider, or the designee, indicating the qualified review agency staff's name and title engaging in the discussions.
 - b) The concurrent review process shall take into consideration, but not be limited to:
 - i) the transition of care of the patient;
 - ii) the time of day of discharge;
 - iii) the patient's transportation limitations; and
 - iv) the welfare and safety of the patient.
- 5.1.2 All initial retrospective adverse determinations for non-emergent health care services that had been ordered by a physician, dentist or other practitioner shall be:
- a) made according to written guidelines which have been reviewed by local participating and practicing providers; and
 - b) any guidelines used to make the adverse determination must be signed by the appropriately qualified and licensed practitioner responsible for the implementation of the utilization review program.
- 5.1.3 Notification of a prospective adverse determination by the review agent shall be mailed or otherwise communicated to the provider of record and to the patient or other appropriate individual as follows:
- a) Within fifteen (15) business days of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent services;
 - b) Within seventy-two (72) hours of receipt of all the information necessary to complete a review of urgent and/or emergent health care services; and
 - c) Prior to the expected date of service.

5.1.4 Notification of a concurrent adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record as follows:

- a) To the provider(s) prior to the end of the current certified period; and
- b) To the patient within one business day of making the adverse determination.

5.1.5 Notification of a retrospective adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record within thirty (30) business days of receipt of a request for payment with all supporting documentation for the covered benefit being reviewed.

Section 6.0 *Internal Appeals Process*

6.1 The review agent shall conform to the following for the appeals of an adverse determination:

6.1.1 The review agent shall maintain and make available a written description of the appeal procedure by which either the patient or the provider of record may seek review of determinations not to authorize a health care service. The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than sixty (60) days from the notice of the adverse determination.

6.1.2 The review agent shall notify, in writing, the patient and provider of record of its decision on the appeal as soon as practical, but in no case later than fifteen (15) or twenty-one (21) business days if verbal notice is given within fifteen (15) business days after receiving the required documentation on the appeal.

6.1.3 The review agent shall also provide for an expedited appeals process for emergent health care services or life threatening situations. Each review agent shall complete the adjudication of expedited appeals within two (2) business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.

6.1.4 All first level appeal adverse determinations shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or a licensed dentist.

6.1.5 A first level appeal adverse determinations shall not be made until an appropriately qualified and licensed review physician, dentist or other practitioner has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician, dentist, other practitioner, other designated or qualified professional or provider responsible for treatment of the patient concerning the medical care , with the exception of the following:

- a) When the attending provider is not reasonably available;

- b) When the attending provider chooses not to speak with agency staff;
 - c) When the attending provider has negotiated an agreement with the review agent for alternative care; and/or
 - d) When the attending provider requests a peer to peer communication prior to the initial adverse determination, the review agency shall then comply with section 4.1.7 a) in responding to such a request. Such requests shall be on the case specific basis unless otherwise arranged for in advance by the provider.
 - i) The review agency shall maintain documentation of the attending provider's request for the two-way direct communication prior to the initial adverse determination.
- 6.1.6 The second level of the internal appeals process shall be offered in those cases where a first level appeal is unsuccessful.
- 6.1.7 Prior to reaching a final decision at the second level of appeal, the review agent shall afford the appealing party an opportunity to inspect the utilization review file and add information to the file.
- 6.1.8 All second level appeal adverse determinations shall be made, signed, and documented by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion.
- 6.1.9 The review agent shall notify the patient and provider of record in writing of the second level appeal determination within the timeframes set in sections 6.1.2 and 6.1.3 herein and shall include:
- a) notice to those parties that the decision may be appealed to the state designated external appeals agencies;
 - b) instructions to initiate an external appeal;
 - c) the fee requirements for completing such an external appeal; and
 - d) a statement that, if the decision of the utilization review agent is overturned by the external appeals agency, the appealing party shall be reimbursed by the review agency within sixty (60) days of the notice of the overturn for their share of the appeal fee paid.
- 6.1.10 The review agent shall maintain records of written appeals and their resolution, and shall provide reports as requested by the Department.

Section 7.0 *External Appeal Requirements*

- 7.1 In cases where the second level of appeal to reverse an adverse determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective external appeals agency, designated by the Director.
- 7.2 Selection criteria for designation will include, but not be limited to, review of the external appeals agency's application with regard to the following:
 - 7.2.1 proposed scope of services;
 - 7.2.2 a fee structure not exceeding the maximum fees permitted by the Director;
 - 7.2.3 utilization review plan;
 - 7.2.4 ability to ensure the confidentiality of health care information in accordance with sections 2.10 and 2.11 herein;
 - 7.2.5 ability to ensure the neutrality of the licensed physician or dentist or other practitioner reviewers;
 - 7.2.6 the type and qualifications of the personnel authorized to perform the reviews;
 - 7.2.7 hours of operation;
 - 7.2.8 administrative and operational policies and procedures;
 - 7.2.9 procedure for reporting intentions to compete for contracts or other arrangements or any other action by the designated external appeals agent which may result in the designated agency becoming a competitor of a certified or waived entity;
 - 7.2.10 policy for ensuring that no conflict of interest exists among the designated external appeals agent and its reviewers and the certified utilization review agents; and
 - 7.2.11 submission of all information requested by the Director.
- 7.3 Designated external appeals agencies shall enter into a written agreement with the Department that includes the following obligations:
 - 7.3.1 Changes in the ownership, operational and/or administrative status of the external appeals agency shall be reported to the Department no less than a minimum of forty-five (45) days prior to such a change.
 - a) If the Director determines that the proposed change(s) may negatively impact the effectiveness and/or objectivity of the designated external appeals agency, the Director reserves the right to revoke said designation.

- 7.3.2 The designated external appeals agency shall report all determinations to the Department within ten (10) business days.
- 7.3.3 The designated external appeals agency shall submit reports due within thirty (30) days of the end of each quarter of the calendar year detailing the following:
- a) the number of appeals conducted and listed by clinical category;
 - b) the outcome of each appeal; and
 - c) the time required to complete each external appeal.
- 7.3.4 The designated external appeals agency shall inform the Department of its intention to compete for contracts or other arrangements which may result in the designated external appeals agency becoming a competitor of a certified or waived utilization review agency.
- 7.3.5 Neutral physicians, dentists, or other practitioners shall be selected from lists:
- a) Mutually agreed upon by the provider associations, insurers, and the purchasers of health services; and
 - b) Used during a twelve (12) month period as the source of names for neutral physician, dentist, or other practitioner reviewers.
- 7.3.6 The designation as an external appeals agency may be terminated without cause by either party to the designation agreement following a ninety (90) day written notice.
- 7.3.7 The designation of an external appeals agency may be terminated immediately if the Director determines that continuation of an existing designation may result in unfair, biased, or unreliable determinations which pose a threat to the public health.
- 7.4 Memoranda of Understanding shall include the obligations of the external appeals agency and the certified review agency.
- 7.4.1 To initiate an external appeal, the patient or provider of record shall file written notification of such appeal with the review agent that rendered the adverse decision. Such notice shall include a check payable to the external appeals agency for one half (½) the pre-determined fee.
- a) The predetermined fee includes all administrative costs and the cost of the reviewing physician or dentist.
 - b) An external appeal must be filed within sixty (60) days of receipt of notice that the second level appeal has been denied.

- c) If the decision of the utilization review agency is overturned by the external appeals agency, the appealing party shall be reimbursed by the utilization review agency within sixty (60) days of the notice of the overturn for their share of the appeal fee paid as defined herein.
- 7.4.2 Within five (5) business days of receipt of written notification, as described in section 7.4.1 herein, the review agent shall forward to the external appeals agency:
 - a) the complete file upon which the adverse decision was based, including the specific findings of the adverse determination;
 - b) the specific review agency criteria utilized in rendering the adverse determination; and
 - c) payment for the pre-determined fee of the external review.
- 7.4.3 The external appeals agency shall not process any appeal without first receiving the total pre-payment required from the appellant and the review agent and the information required in sections 7.4.1 and 7.4.2 herein.
- 7.4.4 The external review shall be based on the following:
 - a) the review criteria utilized by the review agent to make the denial;
 - b) the medical necessity for the care, treatment or service which was denied; and
 - c) the appropriateness of the service delivery which was denied.
- 7.4.5 Neutral physicians, dentists, or other practitioners in the same or similar general specialty as typically manages the health care service shall be utilized to make the external appeal decisions.
- 7.4.6 The neutral physician, dentist, or other practitioner may confer either directly with the review agent and provider, or with physicians or dentists appointed to represent them.
- 7.4.7 For appeals determined to be an emergent health care service as defined in section 1.15 and as provided for in section 6.1.3 herein, an expedited external appeal shall be completed and a final determination shall be made within two (2) business days of receipt.
- 7.4.8 For all non-emergency appeals the external appeals agency shall complete its review and make a final determination within ten (10) business days.
- 7.4.9 The external appeals agency shall provide notice to the patient and provider of record of the outcome of the external appeal.

- a) Such notice must include the rationale for determination.

7.4.10 The decision of the external appeals agency shall be binding; however, any person who is aggrieved by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

Section 8.0 ***Reporting Requirements***

- 8.1 Utilization review agencies shall provide reports and information required on a form prescribed by the Director to determine if the utilization review agencies are in compliance with provisions of Chapter 23-17.12 of the Rhode Island General Laws, as amended, and the rules and regulations herein.
- 8.2 Submission of reports shall be made quarterly, due sixty (60) days after each quarter of the calendar year.
- 8.3 The quarterly reports shall be signed by an authorized representative of the review agency and shall include a statement that the reports submitted are complete and accurate to the best of their knowledge.
- 8.4 Failure to report in accordance with the timeframe set forth in section 8.2 herein, will result in a fine determined by the Director.

Section 9.0 ***Waiver of Requirements***

- 9.1 Except for utilization review agencies performing utilization review activities to determine the necessity and/or appropriateness of substance abuse and mental health care, treatment or services, the Department shall waive all the requirements of the Act, with the exception of those contained in sections 23-17.12-9, (a)(1)-(3), (5), (6), (8), (b)(1)-(6), and (c)(2)-(6), 23-17.12-12, and 23-17.12-14 of the Rhode Island General Laws, as amended, for a review agent that has received, maintains and provides evidence to the Department of accreditation from the utilization review accreditation commission (URAC) or other organization approved by the Director. The waiver shall be applicable only to those services that are included under the accreditation by the utilization review accreditation commission or other approved organization.
- 9.2 The Department shall waive the requirements of the Act and the rules and regulations herein only when a direct conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or the federal government or those activities under other state or federal jurisdictions.
- 9.3 A utilization review agency shall apply for a waiver by submitting a completed application.
- 9.4 The utilization review agency shall submit all its operational policies and procedures that apply to its utilization review activity.
- 9.5 The limitation in section 9.2 notwithstanding, the Department may waive or exempt all or part of the requirements of the Act by mutual written agreement with a state agency when

such waiver or exemption is determined to be necessary and appropriate to the administration of a health care related program.

9.5.1 Such waiver or exemption shall be manifested by a letter of agreement, signed and executed by the Department and the state agency.

Section 10.0 *Denial, Suspension, or Revocation of Certificate*

10.1 The Department may deny a certificate if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by the Act or by any regulations promulgated pursuant to the Act.

10.2 The Department may revoke a certificate and/or impose reasonable monetary penalties not to exceed five thousand dollars (\$5,000) per violation in any case in which:

10.2.1 The review agent fails to comply substantially with the requirements of the Act or of regulations adopted pursuant to the Act;

10.2.2 The review agent fails to comply with the criteria used by it in its application for a certificate; or

10.2.3 The review agent refuses to permit examination by the director to determine compliance with the requirements of this chapter and regulations promulgated pursuant to the authority granted to the director in this chapter; provided, however, that the examination shall be subject to the confidentiality and "need to know" provisions of sections 2.10 and 2.11. These determinations may involve consideration of any written grievances filed with the Department against the review agent by patients or providers.

10.3 Any applicant or certificate holder aggrieved by an order or a decision of the Department made under the Act without a hearing may, within thirty (30) days after notice of the order or decision, make a written request to the Department for a hearing on the order or decision pursuant to § 42-35-15.

Section 11.0 *Penalties*

11.1 A person who substantially violates any provision of the Act or any regulation adopted under the Act or who submits any false information in an application required by the Act is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding five thousand dollars (\$5,000).

Section 12.0 *Variance Procedure*

12.1 The Department may grant a variance upon its own motion or upon request of the utilization review agency from a provision defined herein in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the utilization review agency and that such a variance will be consistent with the overall intent and purpose of this Act and will not be contrary to the public interest, public health, and/or health and safety of enrollees.

12.2 A request for a variance shall be filed by an applicant in writing, setting forth in detail the basis upon which the request is made.

12.2.1 Upon filing of each request for variance with the Department, and within a reasonable period of time thereafter, the Department shall notify the review agency of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the review agency appeals the denial. All hearings and reviews shall be in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws and the *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health (R42-35-PP)*.

Section 13.0 ***Rules Governing Practices and Procedures***

13.1 All hearings and reviews required under the provisions of the Act, as amended, shall be held in accordance with the provisions of the *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health (R42-35-PP)*.

Section 14.0 ***Severability***

12.1 If any provision of the Act or the application of any provision to any person or circumstance shall be held invalid, that invalidity shall not affect the provisions or application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

REFERENCES

1. Chapter 23-17.12 of the Rhode Island General Laws, as amended ("Health Care Services---Utilization Review Act"). Available online:
<http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.12/INDEX.HTM>
2. Chapter 5-37.3 of the Rhode Island General Laws, as amended ("Confidentiality of Health Care Communications and Information Act"). Available online:
<http://www.rilin.state.ri.us/Statutes/TITLE5/5-37.3/INDEX.HTM>
3. Chapter 42-35 of the Rhode Island General Laws, as amended ("Administrative Procedures Act"). Available online: <http://www.rilin.state.ri.us/Statutes/TITLE42/42-35/INDEX.HTM>
4. *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health (R42-35-PP)*, as amended, Rhode Island Department of Health. Available online:
http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH_2945.pdf

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