ARKANSAS REGISTER

Transmittal Sheet

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Department of Health

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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance With Act 434 of 1967 As Amended.

Valetta M. Buck
SIGNATURE

Dir., Division of Health Facility Services
TITLE

November 28, 1990
DATE

007.05.90--003

RULES AND REGULATIONS

FOR

UTILIZATION REVIEW

IN ARKANSAS

1990

ARKANSAS DEPARTMENT OF HEALTH

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FOR

RULES AND REGULATIONS FOR

UTILIZATION REVIEW IN ARKANSAS

PART I

AUTHORITY AND PURPOSE

The following Rules and Regulations for Utilization Review in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the state of Arkansas in Act 537 of 1989.

The purpose of these rules and regulations is to promote the delivery of quality health care in a cost effective manner; foster greater coordination between payors and providers conducting utilization review activities; protect patients, business and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and to ensure that private review agents maintain the confidentiality of medical records.

PART II

DEFINITIONS

For the purpose of these rules and regulations the following definitions shall apply:

A. Board means the State Board of Health.

B. Certificate means a certificate of registration granted by the State Board of Health to a private review agent.

C. Director means the Director of the Section of Health Facility Services and Systems.

D. Hospital means any facility established for the purpose of providing inpatient diagnostic care, and treatment for two (2) or more unrelated persons for more than twenty-four (24) hours may not be conducted or maintained in this state without being licensed.

Part II - Definitions (Continued)

E. Private Review Agent means a non-hospital affiliated entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of an Arkansas business entity or a third party that provides or administers hospital and medical benefits to citizens of this state including a Health Maintenance Organization or any entity offering health insurance policies, contracts or benefits in this state including a health insurer, non-profit health service plan, health insurance service organization, or preferred provider organization.

F. Utilization Review means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to preservice determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes both prospective and concurrent review and may include retrospective review under certain circumstances.

G. Utilization Review Plan means a description of the standards governing utilization review activities performed by a private review agent.

Part II - Definitions (Continued)

H. Utilization Review Representative means the person(s) in a physician office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.

I. Consulting Physician means a Medical Doctor, Doctor of Osteopathy, Dentist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing engaged in the same type of practice and specialty in the locality where the service under review occurred or in a similar locality.

J. Certified Private Review Agent means a private review agent who meets all the criteria for certification as set forth in these rules and regulations, has paid all current fees, and has been assigned a certification number.

PART III

PRIVATE REVIEW AGENTS - APPLICATION FOR CERTIFICATION

A. By December 31, 1990 or a date approved by the Director, a private review agent shall hold a certificate from the Director to conduct utilization review in this state.

B. Completed application for certification shall be submitted to the Director within thirty (30) days of the receipt of the application form.

C. A Private Review Agent seeking certification shall:

1. Submit an application to the Director in a form that the Director requires;
2. Pay an application fee of $750 per year. This fee is payable in advance for both years of the certification (total $1,500). This fee applies to the entity doing the review and not to the individual reviewer;
3. Provide supporting documentation as required by this regulation.

D. An application for certification shall be accompanied by all of the following:

Part III - Private Review Agents - Application for Certification (Continued)

1. A utilization review plan which shall include any or all of the following components used by the private review agent to approve or deny payment or recommend approval or denial of payment in advance for proposed or delivered inpatient or outpatient care or retrospectively approve or deny under certain circumstances:

   a. Elements of review such as:

      1) Preadmission;

      2) Admission;

      3) Preauthorization;

      4) Second surgical opinion;

      5) Discharge planning;

      6) Concurrent;

      7) Retrospective (only on request by the Director);

      8) Readmission review.

   b. Procedures for review including:

      1) Any form used during the review process;

      2) Time frames that shall be met during the review;

      3) A written protocol describing every aspect of the review process.

   c. A description and examples of review standards to be used for the review. This information as provided by Act 537 of 1989 shall be held in confidence and not disclosed to the public.

   d. Circumstances, if any, under which review may be delegated to a hospital utilization review program.

Part III - Private Review Agents - Application for Certification (Continued)

e. The provisions, procedures, and time frames by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent including:

1) A written protocol describing the appeals procedure;

2) Any form which shall be completed during the appeals procedure;

3) Time frames that shall be met during the appeal procedure;

4) The names and qualifications of personnel making final appeal determinations. This information as provided by Act 537 of 1989 shall be held in confidence and not disclosed to the public.

2. The name, number, type, and qualification or qualifications of the personnel either employed or under contract to perform the utilization review. Private review agent will be required to adopt a specific credentialing process for physicians utilized by the private review agent. Any change in the medical director or any consulting physician or chiropractor physician shall be reported to the Director within thirty (30) days. Other personnel changes will be updated on a yearly basis.

Part III - Private Review Agents - Application for Certification (Continued)

3. The policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five (5) days a week during normal business hours in this state; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hours inquiries shall be specified.
4. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed.
5. A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan.
6. A list (names and addresses) of the third party payors for which the private review agent is performing utilization review in this state. This information as provided by act 537 of 1989 shall be held in confidence and not disclosed to the public.

E. A certificate of registration is not transferable.

PART IV

SPECIFIC ASSURANCES

The following specific assurances must be submitted by all applicants:

1. To assure confidentiality, a private review agent must, when contacting a physician's office or hospital, provide its certification number, the caller's name, and professional qualifications to the designated utilization review representative in the physician's office or hospital.

2. The entity providing utilization review will first contact the designated utilization review representative in the physician's office or hospital. Direct contact with the physician will be requested only when necessary information cannot be obtained from the designated representative. The designated utilization review representative must be reasonably available.

3. Any provider targeted for 100% concurrent review must be provided the reason, in writing, by the private review agent.

4. Only information necessary to complete the review process submitted under Part III will be collected.

Part IV - Specific Assurance (Continued)

5. An expedited appeals process shall be available. The physician of record shall have an opportunity to appeal that determination over the phone on an expedited basis. Utilization Review Organizations shall provide for reasonable access to their consulting physician(s) for such appeals.

6. Physician or designated utilization review representative shall be notified, as required by Federal Statute 18 U.S.C. S2511, when telephone conversations are being recorded and shall be provided a copy of the conversation upon request. The physician or utilization review representative who records any conversation with a private review agent shall have like responsibility.

7. For a period of six (6) months following the implementation date of these regulations, the certified private review agency shall send a copy of denials for any covered service to the Director. At the end of this six (6) month period, copies of denials shall be furnished at the request of the Director.

Part IV - Specific Assurance (Continued)

8. Concurrent review should be initiated at a reasonable length of time following admission and at reasonable intervals therafter. Utilization review organizations should not conduct routine daily review of all patients, but should base the frequency of the review on the patient's medical condition. The attending physician and the hospital should be informed of the certified length of stay and the next anticipated review encounter. Routine concurrent review generally should not be necessary earlier than twenty-four (24) hours prior to the lapse of the certified length of stay.

9. A review should be conducted by a physician advisor on a determination not to certify a continued length of stay due to questions of medical necessity or appropriateness. A consulting physician should be reasonably available by telephone to discuss the medical basis for that determination with the attending physician (e.g., criteria, protocols, medical literature).

Part IV - Specific Assurance (Continued)

10. When a determination is made not to certify continued length of stay, the utilization review organization should notify the physician and the hospital of this decision within twenty-four (24) hours by telephone, supplemented by written notification to the hospital, attending physician, and patient* within two (2) working days. This written notification should include an explanation of the principal reason(s) for the determination not to certify and the procedures to initiate an appeal of that determination if the patient so chooses.

11. If after an initial appeal or request for reconsideration, continued stay is not certified due to questions of medical necessity or appropriateness, the patient or provider should have the right to an additional review by another consulting physician of the appropriate medical specialty.

*The term "patient," when used throughout this document, refers to the patient, his/her representative, and/or the enrollee.

PART V

PRIVATE REVIEW AGENTS - RENEWAL OF CERTIFICATION

A. A certificate expires on the second anniversary of its effective date unless certification has been renewed for a two (2) year term.

B. Before the certification expires, the certified private review agent may renew its certification for an additional two (2) year term, if the certified private review agent:

1. Otherwise is entitled to be certified;
2. Pays to the Director the renewal fee of $1,500; and
3. Submits to the Director:
    a. A renewal application on the form that the Director requires;
    b. An update of information as required under Part III of these rules and regulations.

C. The Director shall renew the certification of each certified private review agent if the requirements of these regulations are met.

PART VI

PRIVATE REVIEW AGENTS - REPORTING REQUIREMENTS

The Director may establish reporting requirements to:

A. Evaluate the effectiveness of private review agents;

B. Determine if the utilization review programs are in compliance with the provisions of these rules and regulations.

PART VII

PRIVATE REVIEW AGENTS - DENIAL OR REVOCATION OF CERTIFICATION AND PENALTY

A. The Director shall deny a certificate to an applicant if the Board finds that the applicant does not:

1. Have available the services of a sufficient number of registered nurses, medical records technicians, or similarly qualified persons that are supervised by appropriate physicians to carry out its utilization review activities;
2. Meet any applicable provisions of these rules and regulations relating to the qualifications of private review agents or the performance of utilization review the Board adopts relating to the qualifications of private review agents or the performance of utilization review;
3. Have policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;
4. Make itself accessible to patients and providers five (5) working days a week during normal business hours in this state.

B. The Director may revoke the certification of a private review agent if the Board finds that the agent:

1. Does not comply with performance assurances;
2. Violates any provision of these rules and regulations;
3. Violates any regulation adopted under any provision of this subtitle;
4. Fraudulently or deceptively obtains, attempts to obtain, or uses a certification;

Part VII - Private Review Agents - Denial or Revocation of Certification and Penalty (Continued)

5. Fails to substantially meet the standards and qualifications adopted by the Director;
6. Fails to comply with the regulations adopted by the Board.

C. Before denying or revoking a certificate, the Director shall provide the applicant or certificate holder:
   1. Written notice of the reasons for the denial or revocation;
   2. Thirty (30) days in which to supply additional information demonstrating compliance with the requirements;
   3. The opportunity to request a hearing in accordance with the Arkansas Administrative Procedures Act.

D. If the applicant requests a hearing, the Director shall send a hearing notice by certified mail, return receipt requested, at least thirty (30) days before the hearing.

E. An aggrieved party has the right to take direct judicial appeal of a final decision in accordance with the Arkansas Administrative Procedures Act.

F. A person who violates any provision of these regulations is guilty of a misdemeanor, and on conviction is subject to a penalty not exceeding $1,000. Each day a violation is continued after the first conviction is a separate offense.

PART VIII

PRIVATE REVIEW AGENTS - EXEMPTIONS

A. The Director may waive the requirements of these rules and regulations for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act (Medicare) and Title XIX (Medicaid).

B. No certificate is required for utilization review by any Arkansas licensed pharmacist or pharmacy, or organizations of either, while engaged in the practice of pharmacy in this state.

PART IX

HEALTH INSURANCE PLAN - INSURER ISSUING HEALTH INSURANCE POLICY - GROUP OR BLANKET HEALTH INSURANCE POLICY

All stated entities under Part III shall have a certificate in accordance with these rules and regulations or contract with a private review agent that has a Certificate of Registration. An insurer that does not meet the requirements of this section shall pay any person or hospital entitled to reimbursement under the policy or contract for claims where medical necessity of a covered benefit has been disputed.

PART X

REPEAL

All provisions of these rules and regulations are amendatory to the Arkansas Code of 1987 Annotated.

CERTIFICATION

This is to certify that the foregoing Rules and Regulations for Utilization Review in Arkansas were adopted by the Arkansas State Board of Health at a regular session of said Board held in Little Rock, Arkansas on the 25th day of October, 1990.

M. Joycelyn Elders, M.D.
Secretary of Arkansas State Board of Health
Director, Arkansas Department of Health

The forgoing Rules and Regulations, copy having been filed in my office, are hereby approved on this 26th day of November, 1990.

Bill Clinton
Governor