

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

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96 AUG 29 PM 3:56
OFFICE OF THE SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W.Va. Code §§ 33-2-10, 33-25a-4(1), 33-25A-17a

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 51

TITLE OF RULE BEING PROPOSED: Utilization Management

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

B. Keith Huff
General Counsel

6.80



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

August 29, 1996

HANLEY C. CLARK
Insurance Commissioner

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of the Secretary of State
State Capitol
Charleston, West Virginia 25305

RECEIVED
96 AUG 29 PM 3:58
OFFICE OF THE SECRETARY OF STATE

Dear Ms. Cooper:

Enclosed please find for filing one (1) copy of the following:

- (1) Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee;
- (2) Consent to Proposed Rule;
- (3) Fiscal Note;
- (4) Brief Summary of the Rule;
- (5) Statement of Circumstances;
- (6) Legislative Rule-Making Review Committee Questionnaire; and
- (7) The agency-approved rule entitled "Utilization Management," (Series 51).

Please contact me if further information is required.

Sincerely,

Donna S. Quesenberry
Associate Counsel

DQ/avn
Enclosures



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

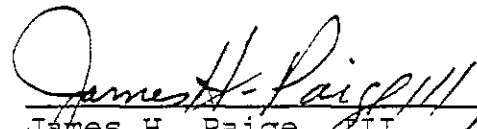
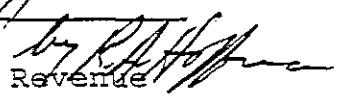
HANLEY C. CLARK
Insurance Commissioner

CONSENT TO FILING OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the filing of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 51, relating to "Utilization Management."

Signed this 26th day of July, 1996.


James H. Paige, III
Secretary of Tax and Revenue 

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Utilization Management (Series 51)

Type of Rule: Legislative Interpretive Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
2019 Washington Street, East
Charleston, West Virginia 25305-0540

=====

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None				
PERSONAL SERVICES	None				
CURRENT EXPENSE	None				
REPAIRS AND ALTERNATIONS	None				
EQUIPMENT	None				
OTHER	None				

2. Explanation of above estimates:

This rule will have no fiscal impact on state, local or federal government.

Rule Title: Utilization Management (Series 51)

3. Objectives of these rules:

The objective of this rule is to set forth standards for utilization management programs established as a component of a health maintenance organizations' quality assurance program.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

May involve some cost to the health maintenance organizations when initially establishing a utilization maintenance program. Over time, the savings produced will outweigh costs.

C. Economic Impact on Citizens/Public at Large.

None

Date: 26 July 96

Signature of Agency Head or Authorized Representative

Stanley S. Clark

Insurance Commissioner
Legislative Rule
Title 114, Series 51

Utilization Management

Title 114, Series 51

BRIEF SUMMARY OF RULE

This proposed rule implements the provisions of the Health Maintenance Organization Act, W.Va. Code §§ 33-25A-1 et. seq., which was amended during the 1996 legislative session by House Bill 4511. The rule sets forth the standards for utilization management programs required to be established as a component of the health maintenance organizations' quality assurance programs.

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STATEMENT OF CIRCUMSTANCES

During the 1996 legislative session, the West Virginia Legislature passed House Bill 4511 which amended the Health Maintenance Organization Act. The rule sets forth the standards for utilization management programs required to be established as a component of the health maintenance organizations' quality assurance programs.

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: August 29, 1996

LEGISLATIVE RULE TITLE: Utilization Management (Series 51)

1. Authorizing statute(s) citation W.Va. Code §§ 33-2-10, 33-25A-4(1), and 33-25A-17A

2. a. Date filed in State Register with Notice of Hearing:
July 26, 1996

b. What other notice, including advertising, did you give of the hearing?
None

c. Date of hearing(s): Comment period ended on
August 26, 1996

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached XX No comments received

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)
August 29, 1996

f. Name and phone number of agency person to contact for additional information:

Donna Quesenberry

Associate Counsel

(304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

Attachment to Question 2(d)

One comment to the proposed rule was received during the comment period, a copy of which is attached hereto. That comment received from John M. Collins of PrimeOne addresses the definition of "qualified medical professional" as "a person licensed or certified pursuant to the laws of the State of West Virginia to provide health care services to persons." PrimeOne's concern surrounds the provision in subsection 4.7, subdivision b which states that "[q]ualified medical professionals shall review decisions for preauthorization of medical services and concurrent review of admissions." As pointed out in the comment, professionals performing utilization management functions, such as preauthorization of medical services and concurrent review of admissions, may be licensed only in the state in which their offices are located. PrimeOne suggests that this section be amended to allow for some type of reciprocity for professionals licensed in other jurisdictions.

The Commissioner's concern is that professionals performing utilization management functions be properly licensed and certified. It is not necessary that those individuals be licensed in the State of West Virginia. Therefore, the Commissioner is in agreement with this recommendation, and amends the definition of qualified medical professional in subsection 2.6 to read as follows:

"Qualified medical professional" means a person licensed or certified pursuant to the laws of the State of West Virginia state in which he or she practices to provide health care services to persons.

A second comment to the proposed rule was received after the comment period had ended. This comment from Lynne E. Fritter of the Health Insurance Association of America is attached hereto. The modifications suggested by HIAA are consistent with those comments received from PrimeOne.

PRIMEONE*An Anthem Health Plan*

P.O. Box 1109
Charleston, West Virginia 25324
1-800-607-7461

August 26, 1996

Direct Dial (304) 353-8707

Donna S. Quesenberry, Associate Counsel
West Virginia Insurance Commissioner
1124 Smith St.
P.O. Box 50540
Charleston, WV 25305-0540

Re: Proposed Rule Series 51 Utilization Management
Proposed Rule Series 52 Diabetes Regulation

Dear Ms. Quesenberry:

I have reviewed the above captioned proposed rules and would like to submit two minor comments for your consideration.

The Utilization Management rule defines qualified medical professional as a person licensed or certified pursuant to the laws of the State of West Virginia to provide health care services to persons. Section 4.7(b) of the rule states that qualified medical professionals shall review decisions for pre-authorization of medical services and concurrent review of admissions. This would therefore seem to limit this activity to individuals only licensed or certified by the State of West Virginia. There are currently HMOs licensed in West Virginia with offices based outside the state. The professionals performing the utilization management functions for these entities may only be licensed in the state in which their offices are located. Many of the newly licensed HMOs as well as future companies that may seek Licensure may wish to perform certain utilization management functions at central facilities based at locations outside of West Virginia. This could include the input of specialist or Medical Directors that serve several companies that are interrelated. I would suggest that you amend this section of the regulation to allow for some type of reciprocity for professionals licensed in other jurisdictions.

The diabetes rule at section 2.1 identifies equipment and supplies that must be covered if determined to be medically necessary by the prescribing physician. These items would appear to be in addition to the items specifically mentioned at



§ 33-15c-1 and § 33-16-16 of the West Virginia Code. One of these items, specifically item c. at section 2.1 is a blood pressure monitoring device. This device is the least likely item to be warranted as medically necessary. HMOs generally do not even cover blood pressure monitoring devices for hypertensive patients or patients with heart disease. The monitoring of blood pressure should more appropriately be taken at a physicians office or in other settings by trained medical professionals. These professionals are trained to recognize the need for additional treatment when high readings occur that the patient may not necessarily recognize. Physicians, primary care physicians in particular, allow patients with high blood pressure to routinely visit their office for blood pressure checks free of charge. Identifying this item as covered in the regulation tends to raise the standard of care. Even though HMOs would not consider it medically necessary for a diabetic patient to monitor their blood pressure at home, the fact that it is identified in the regulation implies that the member is entitled to the coverage. We would suggest that this item be removed from the list.

Thank you for the opportunity to comment on these proposed regulations.

Sincerely,



John M. Collins



Health Insurance Association of America

Attention! HIAA's Annual Anti-Fraud Seminar will be held on September 26-27, 1996, in Des Moines, Iowa



Date: August 26, 1996 **Pages:** 3
 3:18 PM

From: Lynne Fritter

Phone: 202-824-1713 **Fax:**



Deliver To: Donna Quesenberry

Company: West Virginia Insurance Commission **Fax:** 304-558-0412

Phone:

Message:

Disclaimer: The information contained in this telecopy message is intended only for the use of the individual or entry named above. If the reader of this message is not the intended recipient, or as the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this message in error, please immediately notify us by telephone and return the original message to us at the address below via the U.S. Postal Service. Thank you.



Health Insurance Association of America

August 26, 1996

Ms. Donna S. Quesenberry
Associate Counsel
West Virginia Insurance Commission
1124 Smith Street, P.O. Box 50540
Charleston, WV 25305-0540

RE: Title 114, Series 51, Utilization Management of HMOs

Dear Ms. Quesenberry:

On behalf of the Health Insurance Association of America ("HIAA"), I am submitting the comments below on the above-referenced proposed rule. HIAA supports the regulation of utilization review entities, generally, and have only one recommended suggestion.

In Section 2.6, you have defined "qualified medical professional" as a person licensed or certified pursuant to West Virginia state laws. In Section 4.7(b), this rule then requires a qualified medical professional to review decisions for preauthorization of medical services and concurrent review of admissions. We find this requirement inconsistent with the goals of utilization management. While it is important to have local licensing for the attending professional to provide state oversight of local practitioners, the same requirement for utilization management professionals threatens the existence of national review firms and utilization review in general.

In fact, residency restrictions would probably result in arrangements with local clinicians; such arrangements would subject the reviewer to unnecessary peer pressure

Ms. Donna Quesenberry
August 26, 1996
Page Two

and would reduce significantly reviewer consistency and individual effectiveness. Training and general oversight of review and day-to-day management would be problematic and costly. HIAA suggests that you redefine "qualified medical professional" as "a person duly licensed or certified to provide health care services to persons."

If you have any questions, please do not hesitate to call me at (202) 824-1713.

Sincerely,



Lynne E. Fritter
Counsel

cc: Randy Cox

114CSR51
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 51
UTILIZATION MANAGEMENT

Section

- §114-51-1. General.
- §114-51-2. Definitions.
- §114-51-3. Goals of Utilization Management Program.
- §114-51-4. Requirements of Utilization Management Program.
- §114-51-5. Severability.

114CSR51
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 51
UTILIZATION MANAGEMENT

§114-51-1. General.

1.1. Scope. -- The purpose of this rule is to set forth standards for utilization management programs established as a component of the health maintenance organizations' quality assurance programs.

1.2. Authority. -- W. Va. Code §§ 33-2-10, 33-25A-4(1)(b), and 33-25A-17a.

1.3. Filing Date. --

1.4. Effective Date. --

§114-51-2. Definitions.

2.1. "Concurrent review" means the process of continued reassessment of the medical necessity and appropriateness of inpatient care during hospitalization.

2.2. "Criteria" means systematically developed statements used to assess the appropriateness of specific health care decisions, services and outcomes.

2.3. "Health maintenance organization" or "HMO" means a public or private organization which provides, or otherwise makes available to enrollees, health care services, including at a minimum basic health care services, which:

a. Receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

b. Primarily provides physicians' services:

1. Directly through physicians who are either employees or partners of the organization;

Insurance Commissioner

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2. Through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice arrangement; or

3. Through some combination of paragraphs 1 and 2 of this subdivision;

c. Assures the availability, accessibility and quality, including appropriate utilization, of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility; and

d. Offers services through an organized delivery system, in which a primary care physician is designated for each subscriber upon enrollment. The primary care physician is responsible for coordinating the health care of the subscriber and is responsible for referring the subscriber to other providers when necessary: Provided, that when dental care is provided by the health maintenance organization the dentist selected by the subscriber from the list provided by the health maintenance organization shall coordinate the covered dental care of the subscriber, as approved by the primary care physician or the health maintenance organization.

2.4. "Member," "subscriber" or "enrollee" means an individual who has been enrolled in a health maintenance organization, including individuals on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

2.5. "Preauthorization" means prior assessment that proposed medical services are covered by the member's benefit plan and are appropriate for a particular member.

2.6. "Qualified medical professional" means a person licensed or certified pursuant to the laws of the state in which he or she practices to provide health care services to persons.

2.7. "Utilization management" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

§114-51-3. Goals of Utilization Management Program.

3.1. The goals of a health maintenance organization's utilization management program shall be to:

a. Assure the provision of appropriate medical services delivered to members, while simultaneously addressing the effectiveness and quality of care;

b. Monitor, evaluate and improve the delivery of health care and resource utilization;

c. Provide a systematic process that promotes the delivery of medically appropriate care in a timely, effective and efficient manner, while maintaining the quality of health care;

d. Continually upgrade monitoring procedures to re-evaluate performance goals;

e. Monitor utilization practices of provider physicians, hospitals and ancillary providers; and

f. Direct members and providers toward the goal of quality, cost effective health care.

3.2. The health maintenance organization's utilization management program shall include a mechanism for identifying potential quality of care issues and linking them to the HMO's quality assurance program.

§114-51-4. Requirements of Utilization Management Program.

4.1. A health maintenance organization shall develop a utilization management program which adheres to all applicable state and federal laws, federal regulations and state rules.

4.2. Each application for a certificate of authority or renewal thereof filed with the commissioner pursuant to the Health Maintenance Organization Act, W. Va. Code §§ 33-25A-1 et seq., shall be accompanied by a description of the health maintenance organization's utilization management program, which shall include, but not be limited to, the requirements of the utilization management program set forth in this rule.

a. Pursuant to the requirements of W. Va. Code § 33-25A-3, a health maintenance organization shall file notice with the commissioner prior to any modification of the utilization management program.

4.3. A health maintenance organization shall have a documented utilization management (UM) program description that describes both delegated and non-delegated activities.

a. The UM program description shall include, at a minimum, performance goals, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

b. The UM program shall have a mechanism for evaluating and updating the program description on a periodic basis which shall be specified by the health maintenance organization.

4.4. If a health maintenance organization delegates any UM activities to contractors, there shall be evidence of oversight of the contracted entity.

a. The health maintenance organization shall maintain a written description of:

1. The delegated activities;
2. The contractor's accountability for these activities;
3. The frequency of reporting to the health maintenance organization; and
4. The process by which the delegation will be evaluated.

b. The health maintenance organization shall maintain evidence of:

1. Approval of the contractor's UM program; and
2. Evaluation of regular UM reports from the contractor.

c. The health maintenance organization shall be responsible for monitoring the activities of the entity to which it delegates UM activities and for ensuring that the requirements of this rule are met.

4.5. Each health maintenance organization shall have written procedures for assuring that patient-specific information obtained during any UM activity will be:

a. Kept confidential in accordance with applicable federal and state laws; and

b. Used solely for the purposes of utilization management, quality assurance, discharge planning and catastrophic case management.

4.6. The UM program shall have a set of written utilization review decision protocols based on reasonable medical evidence.

a. A health maintenance organization shall have criteria for appropriateness of medical services clearly documented and available, upon request, to participating physicians.

b. A health maintenance organization shall establish a mechanism for checking the consistency of application of criteria across reviewers.

c. A health maintenance organization shall establish a mechanism for updating review criteria on a periodic basis which shall be specified by the health maintenance organization.

4.7. The UM program shall have professionally accepted, pre-established criteria for the preauthorization of services and for concurrent review of admissions.

a. A health maintenance organization shall make efforts to obtain all necessary information, including pertinent clinical information, and consultation with the treating physician, as appropriate.

b. Qualified medical professionals shall review decisions for preauthorization of medical services and concurrent review of admissions.

c. A duly licensed physician shall conduct a review of medical appropriateness on any denial of medical services.

d. At any point during the review process, a licensed physician consultant specially trained in the area of medicine in question shall be available to provide expert opinion regarding medical appropriateness and necessity whenever necessary.

4.8. Decisions regarding provision of medical services shall be made in a timely manner depending upon the urgency of the situation.

a. The health maintenance organization shall establish medically appropriate time frames for urgent, emergency and planned care cases.

b. In those instances in which a health maintenance organization denies medical services, a written notice of denial shall be sent immediately to all involved parties, which shall include, but not be limited to, the subscriber, the primary care physician, and the facility, if appropriate.

1. The written notice of denial shall include the reason for denial and an explanation of the appeal process.

4.9. A health maintenance organization may have policies and procedures in place to evaluate the appropriate use of new medical technologies, or new applications of established technologies, including medical procedures, drugs, and devices. Any policies and procedures in place regarding new medical technologies shall include standards requiring:

a. Appropriate professionals to participate in the development of technology evaluation criteria;

b. The review of information from appropriate health-related government agencies and/or government regulatory bodies and published scientific evidence;

c. Assessment of new technologies and new applications of existing technologies; and

d. Periodic evaluation and update of policies and procedures as technologies and procedures expand and change.

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4.10. A health maintenance organization shall have mechanisms to evaluate the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means.

§114-51-5. Severability.

5.1. If any provision of this rule or the application of this rule to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of the provisions to other persons or circumstances shall not be affected by the holding.