

00-033

HEALTH: REGULATION OF MEDICAL CARE FACILITIES – UTILIZATION REVIEW STANDARDS AND APPEALS.

Statutory scheme pertaining to review of health care service determinations is designed to benefit covered person. Appeals process is designed to be undertaken by provider on behalf of such person. No authority for health care provider to appeal, on own behalf, final adverse decision involving retrospective utilization review denials.

The Honorable John H. Chichester
Member, Senate of Virginia
June 9, 2000

You inquire regarding Article 1.2, Chapter 5 of Title 32.1, §§ 32.1-137.7 through 32.1-137.17 of the *Code of Virginia* ("Article 1.2"), pertaining to utilization review standards and appeals of health care service determinations made by an "insurer, health services plan, managed care health insurance plan licensee, or other entity or person."¹ You specifically ask whether health care providers may appeal, on their own behalf, adverse decisions involving retrospective utilization review denials.

You advise that retrospective medical necessity determinations arise where a health care provider obtains approval to provide services to a health plan member and subsequently submits its treatment plan to the health plan. You also advise that the health plan allegedly reviews the provision of care previously authorized and subsequently denies coverage based on a determination of lack of medical necessity. In such instances, the provider generally may not bill the health plan member. Therefore, neither the individual health plan member nor the provider files an appeal on behalf of the member. Rather, the provider files the appeal on its own behalf since it is the entity suffering financial harm. You assert that the primary issue is whether the timelines and procedures specified in Article 1.2 for the handling of utilization review appeals apply to appeals filed by and on behalf of the provider.²

Section 32.1-137.8(A) specifies that "[n]o utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this article." The use of the word "shall" in § 32.1-137.8(A) implies that its terms are intended to be mandatory, rather than permissive or directive.³ In addition, I also note that when a statute creates a specific grant of authority, the authority exists only to the extent specifically granted in the statute.⁴

A "utilization review entity," as that term is used in § 32.1-137.8(A), is "a person or entity performing utilization review."⁵ "Utilization review" is defined as

a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person.^[6]

The initial utilization review conducted by a health plan of the provision of health care previously authorized for a covered person which results in a denial of coverage already rendered, based on a determination of lack of medical necessity, constitutes an "adverse decision."⁷ Sections 32.1-137.14 and 32.1-137.15 specify the procedures for reviewing an adverse decision. Section 32.1-137.14(A) requires that reconsideration of such a decision "*shall* be requested by the provider on behalf of the covered person." (Emphasis added.) The term "covered person" means "a

subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization."⁸

"The treating provider on behalf of the covered person shall be notified" regarding a decision rendered on a request for reconsideration of an adverse decision.⁹ The decision constitutes a "final adverse decision," which is "a utilization review determination ... in a reconsideration of an adverse decision ... upon which a provider or patient may base an appeal."¹⁰

Section 32.1-137.15 details the procedure for appealing a final adverse decision. Any person or entity performing utilization reviews is required to establish an appeals process for consideration of a final adverse decision appealed "by a covered person, his representative, or his provider."¹¹ It is clear that any such appeal is for the benefit of the covered person, whether the appeal is filed by the covered person or on his behalf by his representative or provider. Furthermore, if the appeal is denied, the notification provided to the appellant must include "a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance ..., the procedures for making such an appeal, and the binding nature and effect of such an appeal."¹²

There are several additional rules of statutory construction that must be applied to this matter. Obviously, the primary goal of statutory construction is to ascertain and give effect to legislative intent.¹³ "[T]he plain, obvious, and rational meaning of a statute is always to be preferred to any curious, narrow, or strained construction."¹⁴ "The manifest intention of the legislature, clearly disclosed by its language, must be applied."¹⁵ "[T]ake the words as written" ... and give them their plain meaning."¹⁶ In addition, statutes should not be construed to frustrate their purpose.¹⁷ Finally, statutes are to be read as a whole rather than in isolated parts.¹⁸

The entire statutory scheme in Article 1.2 pertaining to review of health care service determinations is, in my view, clearly designed for the benefit of the covered person. I am also of the view that the appeals process in Article 1.2 has clearly been designed to be undertaken "by the provider on behalf of the covered person."¹⁹ Therefore, I must conclude that health care providers have no authority to appeal, on their own behalf, final adverse decisions involving cases of retrospective utilization review denials.

¹Section 32.1-137.7 (defining "utilization review").

²Senator Chichester reports that the information contained in paragraph two of this opinion was provided to him by representatives of Potomac Hospital.

³See *Andrews v. Shepherd*, 201 Va. 412, 414-15, 111 S.E.2d 279, 281-82 (1959); see also *Schmidt v. City of Richmond*, 206 Va. 211, 218, 142 S.E.2d 573, 578 (1965); Op. Va. Att'y Gen.: 1999 at 179, 182; 1998 at 56, 58; 1996 at 178, 178; 1991 at 238, 240; 1989 at 250, 251-52; 1985-1986 at 133, 134.

⁴See 2A Norman J. Singer, *Sutherland Statutory Construction* § 47.23 (5th ed. 1992 & Supp. 1999); Op. Va. Att'y Gen.: 1992 at 145, 146; 1989 at 252, 253.

⁵Section 32.1-137.7.

⁶*Id.*

⁷"*Adverse decision*" means a utilization review determination by the utilization review entity that a health service rendered or proposed to be rendered was or is not medically necessary, when

such determination may result in noncoverage of the health service or health services." Section 32.1-137.7.

⁸*Id.*

⁹Section 32.1-137.14(A).

¹⁰Section 32.1-137.7.

¹¹Section 32.1-137.15(A).

¹²*Id.*

¹³See *Turner v. Commonwealth*, 226 Va. 456, 459, 309 S.E.2d 337, 338 (1983); 1993 Op. Va. Att'y Gen. 237, 239.

¹⁴*Turner v. Commonwealth*, 226 Va. at 459, 309 S.E.2d at 338.

¹⁵*Barr v. Town & Country Properties*, 240 Va. 292, 295, 396 S.E.2d 672, 674 (1990) (quoting *Anderson v. Commonwealth*, 182 Va. 560, 566, 29 S.E.2d 838, 841 (1944)).

¹⁶*Adkins v. Com.*, 27 Va. App. 166, 169, 497 S.E.2d 896, 897 (1998) (quoting *Birdsong Peanut Co. v. Cowling*, 8 Va. App. 274, 277, 381 S.E.2d 24, 26 (1989) (quoting *Brown v. Lukhard*, 229 Va. 316, 321, 330 S.E.2d 84, 87 (1985))).

¹⁷See 1982-1983 Op. Va. Att'y Gen. 309, 311 (illogical result frustrates purpose of statute).

¹⁸See *Gallagher v. Commonwealth*, 205 Va. 666, 669, 139 S.E.2d 37, 39 (1964) ("every provision in or part of a statute shall be given effect if possible" (quoting *Tilton v. Commonwealth*, 196 Va. 774, 784, 85 S.E.2d 368, 374 (1955))); Op. Va. Att'y Gen.: 1996 at 26, 27; 1994 at 93, 95; 1985-1986 at 177, 178.

¹⁹Section 32.1-137.14(A).