ALFRED W. GROSS
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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

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October 17, 2003

ADMINISTRATIVE LETTER 2003-9

TO: All Licensed Health Insurers, All Licensed Health Maintenance Organizations, and All Licensed Health Services Plans

RE: Time Requirements of § 38.2-5900 et seq. of the Code of Virginia (14 VAC 5-215-10 et seq.)

Chapter 59 (§ 38.2-5900 et seq. of the Code of Virginia) and the Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (14 VAC 5-215-10 et seq.) require utilization review entities to perform certain acts within specified deadlines. The purpose of this Administrative Letter is to remind companies of those deadlines and the potential consequences of noncompliance.

When the Bureau of Insurance accepts an application for a standard review, the Bureau notifies the utilization review entity and requests that certain documents, including all medical records relevant to the final adverse decision, be provided within twenty working days from the date of the Bureau's letter. Failure to meet this deadline may result in the reversal of the final adverse decision and the imposition of penalties or actions provided by law. Assertions that documents were timely mailed will not be considered without documented proof of mailing. The Commissioner or his designee may, upon good cause shown, provide an extension of time for the submission of records. Such requests must be in writing, must contain a complete explanation as to the need for the extension and must be received by the Bureau before the deadline expires.

When an appeal is reviewed as an expedited review, a utilization review entity shall submit all information and supporting documentation within two days of the acceptance of the appeal by the Bureau. Failure to meet this deadline will not prevent or delay the issuance of a final written ruling by the Commissioner or his designee.

In those instances where the written ruling of the Commissioner or his designee modifies or reverses the utilization review entity's final adverse decision, companies must comply with that ruling immediately. Failure to comply with that ruling within thirty days of the date of the ruling is deemed to be a knowing and willful violation and the Bureau will pursue the imposition of penalties or actions provided by law.

Utilization review entities that are required to provide previously denied services as a result of an external review shall be required to pay such fees as the Commissioner, in his sole discretion, shall deem appropriate to cover the cost of the review. Failure to remit such fees within thirty days of the date notice is mailed to the utilization review entity is deemed to be a knowing and willful violation and the Bureau will pursue the imposition of penalties or actions provided by law.

When a utilization review entity, prior to making a final adverse decision, declines a request for an expedited review, the entity must immediately notify the appellant of the decision by telephone, telefacsimile, or electronic mail and inform the appellant that the appellant has a right to request an expedited appeal with the Bureau of Insurance. This notification must be followed within 24 hours by a written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal the decision to the Bureau of Insurance and providing the appropriate forms by which such appeal may be filed. Failure to comply with this procedure may result in the imposition of penalties or actions provided by law.

If an appeal that is reviewed by a utilization review entity as an expedited appeal results in a final adverse decision, the utilization review entity must immediately notify the person who requested the expedited review of the final adverse decision; immediately notify the appellant, by telephone, telefacsimile, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance without the necessity of providing the justification required pursuant to subdivision 1 of 14 VAC-215-80. The notification must be followed within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal the decision to the Bureau of Insurance and providing the appropriate forms by which such appeal may be filed. Failure to comply with this procedure may result in the imposition of penalties or actions provided by law.

External appeal documents sent to the Bureau via United States Postal Service should be sent to:

External Appeals
Bureau of Insurance
P.O. Box 1157
Richmond VA 23218

External Appeal documents sent to the Bureau via Express Mail services should be sent to:

External Appeals
Bureau of Insurance
1300 East Main Street
Richmond VA 23219

Questions relating to this Administrative Letter should be directed to:

Kim Naoroz
External Appeals
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Cordially,

Alfred W. Gross
Commissioner of Insurance

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