June 13, 1994

ADOPTION OF UTILIZATION REVIEW PROCEDURES

In accordance with Connecticut General Statutes Section 31-280, as amended by section 4 of P.A. 93-228, the following procedures are adopted by the Workers' Compensation Commission concerning utilization review of the reasonableness and appropriateness of medical treatment of claimants. These procedures shall apply to all utilization review entities, employers, insurers and health care providers, except that they shall not apply to approved medical care plans, in which case the utilization review provisions of R.C.S.A. 31-279-10 shall apply.

(a) (1) "Utilization review" means the prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given or proposed to be given to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(2) "Utilization review company" means any company, organization or other entity performing utilization review, except:

(A) An agency of the federal government;

(B) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;

(C) Any agency of the State of Connecticut; or

(D) A hospital's internal quality assurance program except if associated with a health care financing mechanism.

(3) "Enrollee" means an employee who is receiving medical care outside of an approved medical care plan for an injury sustained during the course of his employment and for which compensation is payable under the provisions of Chapter 568.

(4) "Provider of record" or "provider" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment and services rendered to a claimant.

(b) No utilization review company may conduct utilization review in this state unless it is licensed by the insurance commissioner in accordance with Connecticut General Statutes Section 38a-226a.

(1) In accordance with Connecticut General Statutes Sections 38a-226a and 38a-226b, the insurance department shall receive and investigate all grievances filed against utilization review companies by an enrollee.

(2) In the absence of any contractual agreement to the contrary, the enrollee is responsible for requesting certification and for authorizing the provider to release, in a timely manner, all information necessary to conduct the review. A utilization review company shall permit either the enrollee, the enrollee's representative or the provider of record to assist in fulfilling that responsibility.

(c) All utilization review companies must meet the following minimum standards:

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of a prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided that all information necessary to perform the review has been received, prior to the end of the current certified period.

(C) Any notice of determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination and (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal.

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of determinations not to certify an admission, service, procedure or extension of stay.

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the medical arts.

(3) The process established by each utilization review company may include a reasonable period within which an appeal must be filed to be considered.

(4) Each utilization review company shall also provide for an expedited appeals process for emergency or life threatening situations. Each utilization review company shall complete the adjudication of such expedited appeals within two business days of the date the appeal is filed and all information necessary to complete the appeal is received by the utilization review company.

(5) Each utilization review company shall utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners.

(6) Nurses, practitioners and other licensed health professionals making utilization review decisions shall have current licenses from a state licensing agency in the United States or appropriate certification from a recognized accreditation agency in the United States.

(7) In cases where an appeal to reverse a determination not to certify is unsuccessful, each utilization review company should assure that a practitioner in a specialty related to the condition is reasonably available to review the case.

(8) Each utilization review company shall make review staff available by toll-free telephone, at least forty hours per week during normal business hours.

(9) Unless there is a contrary written agreement between the utilization review company and the hospital, all hospitals in this state shall permit each licensed utilization review company to conduct reviews on the premises. Each utilization review company shall conduct its telephone, on-site information gathering reviews and hospital communications during the hospitals' and practitioners' reasonable and normal business hours, unless otherwise mutually agreed. Each utilization review company's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, should carry picture identification and the utilization review company's company identification card.

(10) Each utilization review company shall comply with all applicable federal and state laws to protect the confidentiality of individual medical records. Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(11) Each utilization review company shall allow a minimum of twenty-four hours following an emergency admission, service or procedure for an enrollee or his representative to notify the utilization review company and request certification or continuing treatment for that condition.

(12) The provider of record shall provide to each utilization review company, within a reasonable period of time, all relevant information necessary for the utilization review company to certify the admission, procedure, treatment or length of stay. Failure of the provider to provide such documentation for review shall be grounds for a denial of certification in accordance with the policy of the utilization review company, insurer or employer.

(13) No provider, enrollee or agent thereof may provide to any utilization review company information which is fraudulent or misleading. If fraudulent or misleading statements have occurred, the insurance commissioner shall provide notice of the alleged violation and opportunity to request a hearing in accordance with Chapter 54 to said provider, enrollee, or agent thereof. If a hearing is not requested or if after a hearing the commissioner finds that a violation has in fact occurred, the commissioner may impose a civil penalty (A) of not more than five thousand dollars or (B) commensurate with the value of services provided which were certified as a result of said fraudulent or misleading information. In addition, any allegation or denial made without reasonable cause and found untrue shall subject the party pleading the same to the payment of such reasonable expenses as may be necessary to compensate the insurance department for expenses incurred due to such untrue pleading. All such payments to the department shall be dedicated exclusively to the regulation of utilization review.

(14) No employee of a utilization review company may receive any financial incentive based on the number of denials of certification made by such employee.

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