Department of Insurance
State of Arizona
Office of the Director
Telephone: (602) 364-3471
Telecopier: (602) 364-3470

JANET NAPOLITANO
Governor
www.id.state.az.us

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7256

CHRISTINA URIAS
Director of Insurance

REGULATORY BULLETIN 2007-04[1]

To: Life and Health Insurance Administrators, Utilization Review Agents, Pharmacy Benefit Managers, Disability Insurers, Health Care Service Organizations, Hospital, Medical, Dental and Optometric Service Corporations, Professional Associations and Interested Parties

From: Christina Urias
Director

Date: September 21, 2007

Re: UTILIZATION REVIEW LAWS APPLICABLE TO HEALTH CARE INSURERS AND THIRD PARTY ADMINISTRATORS

INTRODUCTION

This regulatory bulletin addresses the application of Arizona utilization review laws to "coverage-only" decisions. "Coverage-only" decisions do not include clinical or medical necessity review. Arizona law considers a coverage-only decision as a regulated utilization review and a certified or accredited utilization review agent (URA) must make the coverage-only decision. Health care insurers,[2] third party administrators (TPAs)[3] and other entities that make coverage-only decisions must comply with this requirement unless they fall under a statutory exemption such as the exemption for exclusively self-funded or self-insured ERISA plans. See ARS § 20-2502(B)(4).

REGULATED UTILIZATION REVIEW

"'Utilization review' means a system for reviewing the appropriate and efficient allocation of inpatient hospital resources, inpatient medical services and outpatient surgery services that are being given or are proposed to be given to a patient, and of any medical, surgical and health care services or claims for services that may be covered by a health care insurer depending on determinable contingencies, including without limitation outpatient services, in-office consultations with medical specialists, specialized diagnostic testing, mental health services, emergency care and inpatient and outpatient hospital services…." See ARS §20-2501(12).

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[1] This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties you may petition the agency under Arizona Revised Statutes Section 41-1033 for a review of the Statement.

[2] A health care insurer is a "disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, prepaid dental plan organization, medical service corporation, dental service corporation or optometric service corporation or a hospital, medical, dental and optometric service corporation." ARS § 20-2501(A)(8).

[3] Third party administrator is the better-known name for a life and health administrator, which is "any person who collects charges or premiums from or paid on behalf of, or who adjusts or settles claims by, residents of this state in connection with life or health insurance coverage or annuities …." ARS §-485(A)(1).

The "determinable contingencies" referred to in ARS §20-2501(12) are not necessarily medical. Although some states limit regulated utilization review to review of clinical or medical necessity decisions, Arizona does not base coverage decisions based solely on clinical or medical necessity factors. The "adverse decision" definition in the utilization review chapter of ARS Title 20 distinguishes between coverage ("coverage-only") decisions and medical necessity decisions and establishes that the law applies to both:

> "Adverse decision" means a utilization review determination by the utilization review agent that a requested service or claim for service is not a covered service **or** is not medically necessary under the plan if that determination results in a documented denial or nonpayment of the service or claim. ARS § 20-2501(1)(emphasis added).

Furthermore, any adverse decision that results in a documented denial or nonpayment triggers the right to a health care appeal. See ARS §§ 20-2533(A). The right to appeal does not depend on whether the adverse decision is a coverage-only decision or a medical necessity decision. See also, ARS §§20-2537(G) and 20-2533(G).

A health care insurer that conducts utilization review by making coverage-only decisions must either (1) be certified or accredited as a URA, or (2) have a contract with an entity that is certified or accredited as a URA. See ARS §20-2510(A). Health care insurers that make coverage-only decisions are not exempt from the UR laws. By extension, the URA must retain the authority to make final utilization review decisions; a health care insurer that contracts with a URA for utilization review may not retain the right to overrule the URA's decisions or to make final utilization review decisions itself.

Similarly, a TPA must be certified or accredited as a URA if it conducts utilization review by making coverage-only decisions. See ARS § 20-2502(A). TPAs making coverage-only decisions are not exempt from the UR laws.

ILLUSTRATIONS

Illustration No. 1.

A health care insurer denied a claim for durable medical equipment (DME) because the claimant's policy excludes coverage of all DME. To comply with ARS §§ 20-2533(A) and (D), the insurer sent the claimant notice of the denial and the right to a health care appeal. The insurer did not do any clinical review of the diagnosis or services provided. Nonetheless, it decided that a health care service or claim (DME) was not covered, based on a determinable contingency (the policy exclusion). See ARS §20-2501(12)). The insurer performed regulated utilization review and needed to either (1) obtain certification or accreditation as a URA, or (2) contract with an entity that is certified or accredited as a URA. See ARS §20-2510(A).

Illustration No. 2

A TPA adjudicated a claim to a health care insurer for durable medical equipment (DME). After reviewing the benefit plan, the TPA denied the claim because the claimant's policy excludes DME coverage. To comply with ARS §§ 20-2533(A) and (D), the TPA sends the claimant notice of the denial and notice of the right to a health care appeal. The TPA did not do any clinical review of the diagnosis or services provided. Nonetheless, it decided that a health care service or claim (DME) was not covered, based on a determinable contingency (the policy exclusion). See ARS §20-2501(12). The TPA performed regulated utilization review and needed to be certified or accredited as a URA. See ARS §20-2502(A).

Illustration No. 3.

A health care insurer contracts with a licensed URA to provide medical necessity review. The contract between the insurer and the URA expressly provides that the URA will tell the insurer what items or services are medically necessary, and that the insurer will make the final coverage decision about the items or services, based on determinable contingencies (the policy exclusions). In effect, this arrangement makes every final

decision the health care insurer makes into a coverage-only decision under ARS §20-2501(12)). As a result, the insurer is performing regulated utilization review and needs to either (1) obtain certification or accreditation as a URA, or (2) contract with an entity that is certified or accredited as a URA and who will make the final determination with regard to the utilization review. See ARS §20-2510(A).

Illustration No. 4
A TPA that is a pharmacy benefit management company (PBM) received notice of a prescription submitted to a pharmacy by an insured person. The TPA/PBM instructed the pharmacy not to fill the prescription because the benefit plan did not cover the prescribed drug for the insured's diagnosis. To comply with ARS §§ 20-2533(A) and (D), the TPA/PBM sent the insured notice of the denial and notice of the right to a health care appeal. The review process was automated and the TPA/PBM did not perform any clinical review of the diagnosis or the prescription. Nonetheless, it denied a health care service or claim (the prescription) based on a determinable contingency (the diagnosis and the benefit plan). The TPA/PBM performed regulated utilization review and needed a URA certification or accreditation. See ARS §20-2502(A).

SUMMARY:

1. A certified or accredited URA must conduct all regulated utilization review.
2. Regulated utilization review includes both coverage-only and medical necessity decisions.
3. A health care insurer that conducts any regulated utilization review must comply with ARS §20-2510(A).
4. ARS §§20-2510(A)(3) and (4) do not allow an insurer that contracts with a URA for regulated utilization review to reserve the right to make final coverage determinations.
5. A TPA that conducts any regulated utilization review must comply with Arizona's utilization review laws as well as Arizona's TPA laws.

If you have questions about this Regulatory Bulletin, please contact Joy Hubbard, TPA/URA Administrator, at 602-364-2393 or jhubbard@azinsurance.gov.