REFERENCE TITLE: health insurance; utilization review; definition

State of Arizona
House of Representatives
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HB 2381

Introduced by
Representatives McLain: Burges, Gowan, Montenegro, Nichols, Reagan, Weiers
JP

AN ACT

AMENDING SECTION 20-2501, ARIZONA REVISED STATUTES; RELATING TO UTILIZATION REVIEW.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-2501, Arizona Revised Statutes, is amended to read:

20-2501. Definitions; scope

A. In this chapter, unless the context otherwise requires:

1. "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.

2. "Benefits based on the health status of the insured" means a contract of insurance to pay a fixed benefit amount, without regard to the specific services received, to a policyholder who meets certain eligibility criteria based on health status including:

(a) A disability income insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is deemed disabled as defined by the policy terms.

(b) A hospital indemnity policy that pays a fixed daily benefit during hospital confinement.

(c) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who is certified by a licensed health care professional as chronically ill as defined by the policy terms.

(d) A disability insurance policy that pays a fixed daily, weekly or monthly benefit amount to an insured who suffers from a prolonged physical illness, disability or cognitive disorder as defined by the policy terms.

3. "Claim" means a request for payment for a service already provided. Claim does not include:

(a) Claim adjustments for usual and customary charges for a service or coordination of benefits between health care insurers.

(b) A request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

4. "Covered service" means a service that is included in a policy, evidence of coverage or similar document that specifies which services, insurance or other benefits are included or covered.

5. "Denial" means a direct or indirect determination regarding all or part of a request for any service or a direct determination regarding a claim that may trigger a request for review or reconsideration. Denial does not include:

(a) Enforcement of a health care insurer's deductibles, copayments or coinsurance requirements or adjustments for usual and customary charges, deductibles, copayments or coinsurance requirements for a service or coordination of benefits between health care insurers.

(b) The rejection of a request for payment under a policy or contract that pays benefits based on the health status of the insured and that does not reimburse the cost of or provide covered services.

6. "Department" means the department of insurance.

7. "Director" means the director of the department of insurance.

8. "Health care insurer" means 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.

9. "Indirect denial" means a failure to communicate authorization or nonauthorization to the member by the utilization review agent within ten business days after the utilization review agent receives the request for a covered service.

10. "Provider" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for providing care, treatment and services rendered to a patient.

11. "Service" means a diagnostic or therapeutic medical or health care service, benefit or treatment.

12. "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. Utilization review does not include elective requests for the clarification of coverage OR COVERAGE DETERMINATIONS THAT DO NOT EVALUATE MEDICAL NECESSITY OR THE APPROPRIATENESS OF SERVICES.

13. "Utilization review agent" means a person or entity that performs utilization review. For THE purposes of article 2 of this chapter, utilization review agent has the same meaning prescribed in section 20-2530. For THE purposes of this chapter, utilization review agent does not include:

(a) A governmental agency.

(b) An agent that acts on behalf of the governmental agency.

(c) An employee of a utilization review agent.

14. "Utilization review plan" means a summary description of the utilization review guidelines, protocols, procedures and written standards and criteria of a utilization review agent.

B. For the purposes of this chapter, utilization review by an optometric service corporation applies only to nonsurgical medical and health care services.