[Haw. Rev. Stat. §§ 334B-1 through 334B-8.]

§§ 334B-1 through 334B-8: Utilization Review and Managed Care of Mental Health, Alcohol, or Drug Abuse Treatment

§ 334B-1. Purpose.

The legislature finds and declares that the purposes of this chapter are to:

(1) Promote the delivery of quality health care in a cost-effective manner;

(2) Foster greater coordination between health care providers, third-party payors, and others who conduct utilization review and managed care activities;

(3) Protect patients, employers, and health care providers by ensuring that review agents are qualified to perform utilization review and managed care activities and to make informed decisions on the appropriateness of care;

(4) Protect patients' health care interests through public access to the criteria and standards used in utilization review and managed care activities;

(5) Ensure the confidentiality of patients' medical or psychological records in the utilization review and managed care activities in accordance with applicable state and local laws; and

(6) Provide for nondiscriminatory utilization review of treatments for all mental health, alcohol, or drug abuse problems.

§ 334B-2. Definitions.

As used in this chapter:

"Director" means the director of health.

"Health care provider" means any person, corporation, facility, or institution licensed by this State to provide health care services, including but not limited to a physician, hospital or other health care facility, nurse, psychologist, or substance abuse counselor, and officer, employee, or agent of such provider acting in the course and scope of employment or agency related to health care services.

"Health care services" means diagnosis, treatment, medical or psychological evaluation or advice, or other acts as permissible under the health care licensing statutes of this State.

"Physician" means a person licensed to practice medicine under chapter 453.

"Psychologist" means a person licensed to practice psychology under chapter 465.

"Review agent" means a hospital or nonhospital-affiliated person or entity performing utilization review or managed care that is either affiliated with, under contract with, or acting on behalf of:

(1) A business entity in this State; or

(2) A third party that provides or administers hospital, medical, psychological, or other health care benefits to citizens of this State, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization, or preferred provider organization authorized to offer health insurance policies or contracts in this State.

"Utilization review" or "managed care" means a system for reviewing the appropriate and efficient allocation of mental health, alcohol, or drug abuse treatment services given or proposed to be given to a patient or group of patients for the purpose of recommending or determining whether such services should be reimbursed, covered, or provided by an insurer, plan or other entity or person.

"Utilization review plan" means a description of the criteria and standards governing utilization review or managed care activities performed by a review agent.

§ 334B-3. Standards for review agents.

(a) A review agent who approves or denies payment, or who recommends approval or denial of payment for mental health, alcohol, or drug abuse treatment services, or whose review results in approval or denial of payment for these services on a case by case basis, shall conduct utilization review or managed care in this State subject to administrative rules developed by the director.

(b) The director shall establish a complaint resolution panel which shall review any complaints about review agents to determine the facts and establish whether the standards are being followed. If the panel finds consistent violation of the standards, a fiscal penalty may be imposed on the review agent.

(c) The director shall adopt rules pursuant to chapter 91 necessary for the purposes of this chapter. No later than one year after January 1, 1992, the director shall adopt rules establishing:

(1) A requirement that the review agent provide patients and providers with its utilization review or managed care plan including the specific review criteria and standards, procedures and methods to be used in evaluating proposed or delivered mental health, alcohol, or drug abuse treatment services;

(2) A requirement that no determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of mental health, alcohol, or drug abuse treatment services without prior evaluation and concurrence in the adverse determination by another professional with comparable qualifications in a timely manner;

(3) A requirement that a denial of third-party reimbursement or a denial of prior authorization for that service shall include the written evaluation, findings, and concurrence of a professional with comparable qualifications in the relevant specialty or sub-specialty to make a final determination that care rendered or to be rendered was, is, or may be inappropriate;

(4) Provisions by which patients, mental health, alcohol, or drug abuse treatment providers may seek prompt reconsideration by or appeal to the complaint resolution panel of adverse decisions by the review agent;

(5) A requirement that a review agent obtain permission from both the patient and the attending professional prior to attending a treatment session;

(6) A requirement that a representative of the review agent is reasonably accessible to patients, the patient's family, and providers at least five days a week during normal business hours and that payment may not be denied solely because the review agent is not available;

(7) Policies and procedures to ensure that all applicable state and federal laws protecting the confidentiality of individual medical records are followed;

(8) Policies and procedures to ensure that the amount or type of information requested by any system of managed care or utilization review be minimal, be pertinent to the needs of providing appropriate utilization review or managed care services, and shall not violate patient rights and confidentiality;

(9) A requirement that the referring professional be informed prior to the decision for a denial of treatment benefits; provided that, once the adverse determination has been made, this decision shall be communicated in a timely [manner] to all affected parties;

(10) A prohibition of a contract provision between or among any combination of the review agent, the provider, a business entity, or third-party payor that may constitute a conflict of interest;

(11) A requirement that an orderly process be established for the timely and impartial internal resolution of problems prior to the use of the complaint process; and

(12) The process by which complaints shall be handled by the complaint resolution panel.

(d) Nothing in this process shall be deemed to deprive a patient or mental health, alcohol, or drug abuse treatment provider of any other cause of action available under state law.

§ 334B-4. Waiver.

This chapter shall not apply to a review agent that operates under contract with the federal government for utilization review activities relating to recipients and health care providers under Title XVIII of the Social Security Act, Title XIX of the Social Security Act, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

§ 334B-5. Confidentiality.

A review agent may not disclose or publish individual medical or psychological records or any other confidential medical or psychological information obtained in the performance of utilization review or managed care activities.

§ 334B-6. Penalty for violation.

Any person or agency who violates any provision of this chapter or any rule adopted pursuant to this chapter or who submits any false information shall be guilty of a misdemeanor and upon conviction shall be subject to a penalty of not more than $1,000.

§ 334B-7. Appeal by aggrieved party.

Any person aggrieved by a final decision of the complaint resolution panel in a contested case under this chapter may appeal to the director.

§ 334B-8. Annual report.

The director shall submit an annual report to the governor and the legislature at least twenty days prior to the convening of each regular session concerning the conduct of review agents that have been reported to the complaint resolution panel. The report shall include an analysis of complaints filed against agents by patients or their representatives, or providers.