

# **Overview Of Virginia Managed Care Laws Affecting Physicians And Their Patients**

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Physicians and their patients sometimes feel overwhelmed by the perceived power and control exercised by the managed care industry. Although existing law may not satisfactorily protect the physician and patient in many circumstances, there are a variety of continually evolving Virginia laws which may afford some relief to physicians and their patients in their interactions with managed care plans. It is hoped that the following survey of many of the relevant Virginia laws will prove useful to Virginia's physicians and their counsel.

1. Fair Business Practices Act: § 38.2-3407.15.<sup>3</sup> Covered provider contracts must "contain specific provisions which shall require the carrier to adhere to and comply with [certain] minimum fair business standards in the processing and payment of claims." Specifically, the statute requires carriers to (a) pay clean claims within 40 days after receipt, (b) request any additional required information or documentation about the claim within 30 days after receipt, (c) pay any accrued interest on claims within 60 days after the claim payment, and (d) establish reasonable policies regarding pre-certification, retroactive denials, reimbursement and claims processing and make copies of all relevant policies available at the time a contract is presented for execution, in advance of any amendment, and within 10 days of a provider's request. The statute also (i) places a 12-month time limit on a carrier's right to set-off in event of a retroactive denial (absent fraud or certain other exceptions), (ii) limits a carrier's right to refuse to pay previously approved claims, (iii) requires at least 90 days notice of contract changes, (iv) affords providers important remedies and protections from carrier retribution, (v) permits the Bureau of Insurance to address certain violations, and (vi) makes non-compliance with the statute to be also a violation of the unfair claim settlement practices statute. See § 38.2-510(A)(15). The statute applies only to carriers which are subject to regulation by Virginia's insurance laws and is effective for provider contracts entered, amended, extended or renewed after July 1, 1999.

2. Patient Protection Act: § 38.2-3407.10. This statute sets out the rules for the establishment and operation of provider panels by carriers, including health maintenance organizations ("HMOs"). The rules require or provide for: (a) notice of the establishment of a panel; (b) 90 days notice of termination of a provider if not for cause; (c) notice to primary care physicians of termination of a specialist; (d) notice to purchasers of all types of provider payment arrangements; (e) prohibition of denial or termination of a provider for reasons of gender, race, age, religion or national origin; (f) the right of a provider who is not terminated for cause to continue to provide care, at the enrollee's option (i) for up to 90 days to existing patients after the notice date of the provider's termination, (ii) until the completion of postpartum care to an enrollee who has entered the second trimester of pregnancy at the time of the provider's termination, and (iii) until the end of the enrollee's life with respect to a terminal illness diagnosed at the time of the provider's

termination; (g) prohibition against requiring provider indemnification for a carrier's negligence, willful misconduct, or breach of contract; (h) prohibition against requiring a provider to waive his right to legal redress against a carrier; and (i) prohibition against interfering in the discussion of medical treatment options between a patient and provider.

1999 amendments to the Act require that any carrier requiring preauthorization prior to rendering medical treatment shall have personnel available to provide such authorization at all times when such preauthorization is required. A similar provision is included in the Fair Business Practices Act discussed in paragraph 1 above. §38.2-3407(B)(4)(a).

The 1999 amendments also require that carriers provide to their group policyholders written notice of any benefit reductions during the contract period at least 60 days before such benefit reductions become effective. Group policyholders shall, in turn, provide to their enrollees written notice of any benefit reductions during the contract period at least 30 days before such benefit reductions become effective.

Finally, the 1999 amendments state that no contract between a provider and a carrier shall include provisions which require a provider to deny covered services that such provider knows to be medically necessary and appropriate that are provided with respect to enrollees with similar medical conditions. This may restrict the use of improper financial incentives in provider contracts.

Most of the 1999 amendments, including the extension of the time limits from 60 to 90 days for terminating provider contracts without cause and for notifying patients of the termination, are effective for provider contracts entered into or renewed on or after July 1, 1999.

3. Prohibited Practices: §§ 38.2-4312 (HMOs), -5806 (MCHIPs). No HMO may discriminate because of race, creed, color, sex or religion in the selection of providers, nor may an HMO "unreasonably discriminate" against certain listed providers. It is not "unreasonable discrimination" for an HMO to select, in its judgment, the number of providers necessary to render the services offered. The MCHIP statute prohibits refusals to cover based on health, provides certain protections for residents of continuing care facilities who are referred to skilled nursing units, and provides certain limitations on agreements to arbitrate complaints.

4. Physician Exclusion from State Employees Plan: § 2.1-20.1(F). Any self-insured group health plan established by the Department of Personnel and Training (for state employees) which uses a network of preferred providers may not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine so long as the physician otherwise meets the plan criteria established by the Department. Efforts to expand this legislation to all health plans have been unsuccessful.

5. Any Willing Provider: §§ 38.2-3407 (insurers), -4209 (non-stock corporations). Preferred provider organizations ("PPOs") may establish "terms and conditions" for participation, but the terms and conditions shall not discriminate unreasonably against or among providers. Any

physician or other listed provider willing to meet the terms and conditions offered to it shall not be excluded. The statutes and case law permit discrimination based on cost, quality and access. Non-preferred providers must be paid, but need not be paid on the same basis as preferred providers. These statutes do not apply to HMOs.

6. Interest on Unpaid Claims: §§ 38.2-3407.1, - 4306.1. If the carrier does not timely pay a claim, the claimant or assignee is entitled to interest at the legal rate of interest beginning 15 days (30 days in the case of an HMO) after submission of all necessary documentation. These sections do not apply to claims for which payment will be made directly to the provider pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the carrier's obligation. Failure to pay interest timely may also violate the fair business practices statute (§ 38.2-3407.15(B)(3)).

7. Review of HMOs: § 32.1-122.10:01. The State Health Commission must annually examine and issue reports to consumers regarding the quality of HMO health care services through gathering and comparison of statistical information in several categories, including effectiveness, availability, and cost of care. The DOH also has certain responsibilities with respect to HMO complaint systems, including preparation of an annual summary of complaints filed by HMO enrollees.

8. MCHIPS: §§ 32.1-137.1 to -137.16 and 38.2-5800 to -5811. Legislation enacted in 1998 and 1999 attempts to apply uniform rules to all managed care plans in a range of areas, including complaint processes, quality assurance, and provider protection. Regulations are in the process of being promulgated by the Board of Health and are anticipated to be effective in December, 1999. Proposed Regulations for the Certification of Managed Care Health Insurance Plans, 12 VAC 5-408.

- MCHIPS. A managed care health insurance plan ("MCHIP") is defined as any health insurance arrangement offered by a health carrier which both (i) contains provider incentive arrangements (including economic credentialing) and (ii) encourages patients to receive care from participating providers by differing payments for benefits. HMOs and PPOs are deemed to be offering MCHIPs in most circumstances.
- Quality Assurance Certificate. Every health carrier responsible for a MCHIP must apply for quality assurance certification with DOH by December 1, 1999, and must obtain a certificate of quality assurance on or before July 1, 2000, with biennial renewals. The certificate is to be issued only if it is adequately demonstrated to DOH that the MCHIP's health carrier "has in place and complies with" systems which are "reasonable and adequate" for (i) addressing patient complaints, (ii) assessing patient satisfaction, (iii) providing access to services, (iv) encouraging preventive services, (v) credentialing providers, (vi) informing patients and providers of MCHIP policies, (vii) assessing, measuring and improving health status--including outcome measures and accountability, (viii) protecting confidentiality of medical records, (ix) utilization review, and (x) addressing "such other requirements as the Board may establish by regulation consistent

with this article.” The permitted scope of the regulations is limited to matters “governing the quality of care” provided by MCHIPs “consistent with this article.” NCQA standards may be considered. Pending the development of regulations, existing DOH oversight of HMO quality will continue under prior law and the Bureau of Insurance/DOH Memorandum of Agreement.

The proposed MCHIP regulations contemplate a comprehensive onsite examination of MCHIPs both to ensure that a MCHIP has appropriate quality assurance systems in place, “and that the systems are successfully implemented and result in the improvement of enrollees’ health outcomes and the delivery of their care.” Proposed 12 VAC 5-408-90(A). The examination will be conducted at least every four years, and more frequently if necessary. This examination is in addition to the Bureau of Insurance’s market conduct examination.

Network adequacy is an important focus of certification and of the examination. The proposed regulations set out many specific requirements for network adequacy, including requiring that the normal travel time to a primary care physician not exceed 30 minutes and to a specialist not exceed 60 minutes. Proposed 12 VAC 5-408-260. Further, MCHIPs must have a mechanism to inform patients and providers, on request, of the MCHIP’s annual quality improvement performance results, must have a system for evaluating outcomes and processes for clinical care and must inform providers and patients of services such as quality assurance, credentialing and utilization management which are delegated to another entity. Proposed 12 VAC 5-408-230(N), 240, 300 and 340(B).

The authority of DOH to look at providers in the context of an investigation of a health carrier’s compliance may make it possible to scrutinize strict gatekeeper structures, economic credentialing and aggressive provider incentive arrangements if DOH concludes that the arrangements adversely affect quality. Indeed, the proposed regulations specifically require that a description be provided of all payment arrangements used to compensate providers. Proposed 12 VAC 5-408-160(G)(8). See also §38.2-3407.10(C)(4)(a) and (N).

Although not affording complete due process to providers, the proposed regulations include a number of important restrictions on a MCHIP’s right to exclude providers arbitrarily. Proposed 12 VAC 5-408-170. Among the significant protocols for provider credentialing and recredentialing included in the proposed regulations are (a) the prohibition of unfavorable credentialing “solely because the provider treats a substantial number of patients who require expensive or uncompensated care”, (b) a requirement that participation policies be established and “include a range of actions to be taken to improve performance prior to termination”, (c) a requirement that provider termination or suspension “be supported by documented records of noncompliance with specific plan expectations and requirements for providers,” and (d) a required provider appeals process in the provider contract which affords the provider access to the information relied on and ensures that “profession specific providers actively participating in the plan shall be included in reviewing appeals and making recommendations for action.”

- Complaint System: § 32.1-137.6. DOH shall examine each carrier responsible for a MCHIP for compliance with the regulations at the time of certification, and additional examinations or investigations may be conducted when appropriate. Patient quality complaints must now be acted on by DOH, in cooperation with the Bureau of Insurance. DOH will not adjudicate individual controversies but will look at patient care problems which appear systemic in nature.

It is the Bureau's position that the complaint systems discussed in Title 32.1 and in new Chapter 58 of Title 38.2 are the same, and that a MCHIP need not have a system for dealing with complaints by providers, competing HMOs or others (other than covered persons). However, the Bureau and DOH may still receive, consider and act on any complaint by a provider, a competing HMO or other person regarding quality matters, violations of law, or other appropriate issues. The Bureau believes the absence of a requirement that an HMO have a "system" for addressing complaints by non-covered persons is not intended to mean that those issues will not be addressed, where appropriate, by the relevant regulatory agency. Under the proposed regulations, the complaint may be made by the patient or by a provider acting on the patient's behalf, but must relate to patient care or quality. 12 VAC 5-408-130 and 180. It is also significant that in its review of the complaint system, DOH is to consider complaints by the covered person's "duly authorized representative."

- Practice of Medicine. HMOs are deemed not to be "engaged in the unlawful practice of medicine" (§ 38.2-4319(C)). The comparable statute dealing with MCHIPs (§ 38.2-5810) removes "unlawful" and adds "solely by virtue of compliance with this Chapter." See paragraph 24 below.
- Penalties: § 32.1-137.5. When the MCHIP provisions become effective, DOH will have authority to issue civil money penalties or to suspend or revoke certificates of quality assurance upon a finding of non-compliance. The scope of this provision will be defined in regulations. See proposed 12 VAC 5-408-140. Penalties and restitution continue to be permitted for violation of the rules of the State Corporation Commission (the Bureau of Insurance) or DOH or for quality reasons. See §§ 38.2-218 to -220, -4316 and -5809; § 2.1-28; § 32.1-27.

9. Utilization Review Standards and Appeals Utilization Review Entities and Private Review Agents: §§ 32.1-137.7 to -137.17; §§ 32.1-138.6 to -138.15. Existing utilization review law continues, although oversight was moved in 1998 from the Bureau of Insurance to DOH. A utilization review entity is an entity which performs medical necessity and utilization review functions for its affiliated carrier, and a private review agent is an entity which performs review functions for other carriers. The private review agent statute specifically excludes from its scope entities performing review functions for self-insured plans.

The 1998 law provided that complaints and adverse utilization review decisions must be in writing. DOH may review the standards used for utilization review but likely may not impose sanctions for utilization review violations. These issues may be addressed by the quality assurance regulations under § 32.1-137.1 to -137.6 (see paragraph 8(b) above). See proposed 12 VAC 5-408-370.

Utilization review entities are required to establish reasonable standards and criteria to be applied in making utilization review determinations. Physician input is required, the standards must be “objective, clinically valid and compatible with established principles of health care,” and deviations from norms must be permitted where justified. A utilization review entity must adopt a plan that establishes the protocols for reviews (including expedited reviews) and includes rules for reconsideration of adverse decisions. An appeals process, including expedited appeals, generally must also be included, and appeals must be reviewed by a disinterested peer of the treating physician. Proposals to require “peers” of the treating provider to have a Virginia license and to subject those making adverse decisions to the scrutiny of the Board of Medicine have not been accepted. Physicians have the right to receive notices of the review process, a list of physician advisors and their specialty areas, and a copy of the relevant utilization review plan standards and criteria used for the review. All MCHIPs will need to comply with the utilization review entity laws under the proposed regulations. Proposed 12 VAC 5-408-370.

No entity performing utilization review shall terminate its contractual arrangement with or penalize a provider for advocating the interest of his patients in the appeals process unless the provider engages in a pattern of filing appeals without merit.

The utilization review entity standards and protocols outlined above do not, by their terms, apply to private review agents. While the private review agent statute and regulations do impose certain standards, future legislation may be needed to ensure that the same standards apply to both types of review organizations. See 12 VAC 5-405.

10. External Appeals and Ombudsmen: § 32.1-137.15; §§ 38.2-5900 to -5905. 1999 legislation establishes a process of independent external review for covered persons receiving a final adverse decision from the Bureau of Insurance. If the Bureau determines that (a) the claim is made by a covered person or a treating provider with the consent of the covered person, (b) the claim is in connection with a covered service that costs more than \$500, (c) the claimant has exhausted all available utilization review complaint and appeals procedures, and (d) the claimant has provided all

information necessary to begin review, an impartial health entity under contract with the Bureau of Insurance shall review the final adverse decision to determine whether the decision is objective, clinically valid, compatible with established principles of health care, and contractually appropriate.

Each individual seeking such review must pay a filing fee of \$50. Insurers writing accident and sickness insurance in Virginia will pay an assessment not to exceed 0.015 percent of the direct gross premium income during the preceding year to fund such appeals process. The impartial health entity will issue a written recommendation within 30 days of the acceptance of the appeal by the Bureau of Insurance and the Commissioner of Insurance will issue a binding order carrying out the recommendation of the impartial health entity.

These appeals provisions become effective on the earlier of (i) 90 days following the promulgation of regulations by the State Corporation Commission or (ii) July 1, 2000. A similar appeals process is available, within the Department of Personnel and Training, for state employees who receive health care coverage through the state health insurance plan. See § 2.1-20.1(B)(4).

Effective July 1, 1999, an Office of Managed Care Ombudsman is established within the Bureau of Insurance and is charged with promoting and protecting the interests of covered persons under health insurance plans in Virginia. The duties of the Ombudsman include assisting persons in understanding their rights and procedure available to them under their managed care plan, developing information on the types of managed health insurance plans available in Virginia, and monitoring and providing information to the General Assembly on managed care issues. The Department of Personnel and Training is also required to appoint an Ombudsman to similarly assist state health insurance plan participants. See § 2.1-20.1(L).

11. Optional Point of Service Benefit: § 38.2-3407.12. Any carrier must include an out-of-network benefit option in any offering made to a group contract holder in Virginia on a fully insured basis. This 1998 law is designed to permit employees to select and pay for an out-of-network option at time of enrollment. Limitations are placed on the capacity of a carrier to discourage use of this benefit through unreasonable co-payments or provider reimbursement.

12. Access to Providers Generally: §§ 38.2-4312.3, - 4316, -5807 and -5803(B); § 32.1-137.2(C)(iii). HMOs generally must demonstrate the availability of adequate providers to cover their service area. HMOs must provide 24-hour access to emergency care and must reimburse providers for medical screening and stabilization services necessary to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act. DOH shall evaluate access to care as a part of its quality oversight of MCHIPs. If a primary care physician is required, MCHIPs must afford patients certain flexibility in selecting or changing PCPs. See paragraph 8 b above. See also § 38.2-3407.10, discussed above at paragraph 2.

13. Access to Obstetrician-Gynecologists: § 38.2-3407.11. This section affords females aged 13 or older a right of direct access to a participating ob-gyn for an annual exam and routine services incident to and rendered during an annual visit.

14. Access to Cancer Treatment: § 38.2-3407.11:2, -3407.6:1; §§ 32.1-137.10 to 137.15. Health plans must permit any covered individual who has been diagnosed with cancer to have a standing referral to a board-certified physician in pain management or an oncologist who is authorized to provide services under such plan and has been selected by the cancer patient.

Utilization review agents must make all decisions on prescriptions for the alleviation of cancer pain within 24 hours, with expedited appeals available to challenge adverse decisions. Health plans may not deny prescribed drugs approved by the FDA for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent.

15. Access to Specialists: § 38.2-3407.11:1; § 2.1-20.1(B)(14). Health insurance plans and the state employees' health plan must provide access to specialists for individuals with ongoing special conditions. The phrase "special condition" means a condition or disease that (a) is life-threatening, degenerative, or disabling and (b) requires specialized medical care over a prolonged period of time. After a covered individual is referred to the specialist, the specialist may authorize tests, procedures, referrals, and other medical services to the same extent as could be authorized by the individual's primary care provider. Additionally, procedures must be developed whereby a covered person with an ongoing special condition may receive a standing referral to a specialist. Health plans may require a specialist to provide written notification to the individual's primary care physician, including a description of the services rendered.

16. Prescription Drug Formularies: § 38.2-3407.9:01; § 2.1-20.1(H)(2). Health insurance plans and the state employees' health plan may develop closed prescription drug formularies only after consultation with a pharmacy and therapeutics committee. A majority of the committee's members will be physicians, pharmacists, and other health care providers. Additionally, these health plans must allow a covered person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs within the covered benefits, a specific, medically necessary, nonformulary prescription drug if the formulary drug is determined to be an inappropriate therapy for the medical condition of the enrollee. The carrier must act on a nonformulary request within one business day of receipt of the request.

17. Miscellaneous Mandated Benefits: §§ 38.2-3407.16 to 3419.1. These provisions set out a number of mandated benefits required to be included in most commercial group health plans offered in the Commonwealth on a fully insured basis, including specified coverage for: (a) services of qualified non-physicians (see also § 38.2-4221), (b) dependent children, (c) newborn children, (d) child health supervision services, (e) adopted children, (f) mental health and substance abuse services, (g) obstetrical and postpartum services, as an option, and the duration limits, deductibles, coinsurance, and copayments for obstetrical services, (h) pregnancy after rape or incest, (i) mammograms, (j) annual pap smears and certain related testing, (k) diagnostic and surgical treatment for bones and joints of the head, neck, face or jaw, (l) certain bone marrow and stem cell transplants, (m) hemophilia treatments, (n) early intervention services, (o) prostate screening, (p) reconstructive breast surgery, (q) mastectomy and hysterectomy length of stay, (r) hospice care, and (s) diabetes and

diabetes equipment, supplies and self-management training and education. Many of these mandated coverages are also included in the state employees health plan. § 2.1-20.1(B).

Effective July 1, 2000, health plans, including the state employees' plan, must provide benefits for treatment of biologically-based mental illness on the same terms as other illnesses or conditions, except for individual or small group policies. This section expires July 1, 2004; however, ongoing studies will be conducted to determine the effects of the coverage.

18. Unfair Trade Practices: §§ 38.2-500 to -517. No person may (a) make certain misrepresentations in connection with a policy, (b) make any defamatory statement that is false, maliciously critical and calculated to injure a person with respect to the business of insurance, or (c) engage in concerted action to boycott, coerce or intimidate if it would tend to result in an unreasonable restraint of trade or monopoly in the business of insurance. Limited protections are provided to policyholders with respect to certain unfair discrimination.

Although no private right of action is created, carrier unfair settlement practices which occur with such frequency as to indicate a general business practice are prohibited if they result from, among other things: (a) failing to acknowledge and act on claims reasonably promptly, (b) failing to adopt and implement reasonable standards for prompt investigation of claims, (c) refusing arbitrarily and unreasonably to pay claims, (d) failing to affirm or deny coverage within a reasonable time, (e) compelling insureds to institute litigation by offering less than the amount due, (f) making claims payments to insureds or beneficiaries not accompanied by a statement of the coverage, (g) delaying investigation or payment of a claim by requiring the insured or his physician to submit a preliminary claim report and forward proof of loss if substantially the same, (h) failing promptly to provide a reasonable explanation of the legal or factual basis for denying a claim or (i) violating the fair business practices statute (§ 38.2-3407.15). A carrier also must not fail to disclose information required by any rules or regulations of the Commission.

19. Medical Records: §§ 54.1-2403.2 to .3; -2405 to -2406; §§ 38.2-600 and 606; §§32.1-127.1:03, -137.12 and -138.13 and §§8.01-399 to 413. Medical records maintained by a provider shall be the property of the provider. Rules for medical record confidentiality, subpoenas, storage, release and transfer are addressed. Of particular relevance are the rules relating to the release of records to carriers or their utilization review entities. §32.1-127.1:03(D)(16) and §38.2-606. See §§37.1-225 et seq. (setting out important rules for disclosure of medical records to, and used by, payors and for patient consents). The proposed MCHIP regulations also address use of medical records in connection with utilization review activities. Proposed 12 VAC 5-408-210(B) and 370. See §§32.1-137.12 and 138.13 and 12 VAC 5-405-100. There are also important federal law limitations. See e.g. 42 USC §§ 290 dd et seq.

20. Carrier Insolvency: §§ 38.2-4310, -4317, -4317.1, -5805(C). Certain protections against HMO and MCHIP insolvency are provided; however, they may be of little practical benefit to unpaid providers. Indeed, no participating provider may receive reimbursement from the Commission's insolvency assessments; providers may not look to the enrollee in event of non-

payment by the HMO; and the provider must give at least 60 days notice to the HMO of termination of the provider contract.

21. Health Practitioner's Intervention Program: §§ 54.1-2515 to -2518. A practitioner with a physical or mental disability (including substance abuse) may, under appropriate circumstances, enter the HPIP program and have certain disciplinary proceedings stayed, so long as the practitioner is in compliance with the program.

Participation may effectively protect a practitioner from exclusion by a managed care plan since the absence of an adverse disciplinary action may avoid a Data Bank report which, in turn, may avoid or delay de-credentialing by a carrier.

22. Malpractice Against HMOs. Legislation proposing to hold MCHIPs liable for medical malpractice was defeated in the 1999 General Assembly Session. A careful reading of the Code, however, suggests that an HMO may be liable for malpractice, subject to ERISA limitations for denial of coverage and administrative decisions. An HMO is defined as a "health care provider" and "malpractice" is defined as "any tort based on health care services ... by a health care provider." § 8.01-581.1. Section 8.01-581.20(A) discusses the "standard of care" in Virginia, a violation of which may constitute a tort, and specifically refers to actions against "any ... other health care provider." This could arguably include HMOs. Direct legislation may be needed to settle the issue.

23. Malpractice Cap: § 8.01-581.15. Physicians and other health care providers enjoyed the protection of the \$1 million cap on malpractice claims through July 31, 1999. After the Virginia Supreme Court upheld the constitutionality of the cap, compromise legislation was adopted during the 1999 Session to raise the amount recoverable in medical malpractice actions from \$1 million to \$1.5 million per incident, effective August 1, 1999. The \$1.5 million limit will increase by \$50,000 on July 1 of each year until July 1, 2006, and by \$75,000 on July 1 of 2007 and 2008, to reach a total of \$2 million per incident. Interestingly, the \$1 million liability limit for Internal Revenue Code § 501(c)(3) hospitals with appropriate insurance continues to apply under § 8.01-38.

Earlier changes to the definition of "health care provider" in § 8.01-581.1 extended the malpractice cap protection to physician practice arrangements such as professional limited liability companies and any other entity "which employs or engages a licensed health care provider and which primarily renders health care services."

24. Practice of Medicine: §§ 54.1-2902, -2903. It is unlawful to practice medicine without a license. Any person is regarded as practicing medicine "who actually engages in such practice." See paragraph 8d above. The law is evolving as to whether a carrier's utilization review decisions or the actions of its medical directors may constitute the practice of medicine.

25. Privileged Communications: §§ 8.01-399 and 581.17. Peer review materials are largely privileged. The authority of DOH to investigate HMO quality hopefully should not diminish

this protection. Likewise, communications with patients are subject to a broad privilege unless the physical or mental condition of the patient has been placed at issue.

26. Practitioner Reporting and Immunity: §§ 54.1-2400.1, -2906 to -2909; §§32.1-38, -88(B), -127.3; §§8.01-581.13 to -581.19:1; and §§63.1-248.3 and 248.5. Broad immunity is afforded to certain practitioners in connection with most peer and utilization review activities.

The chief of staff of every hospital is required to report to the Board of Medicine certain misconduct by physicians on the medical staff. Subject to federal law, physicians are also required to report to the appropriate regulatory board treatment of a health professional for drug addiction, chronic alcoholism or mental disorders unless it is probable that the physician is not a danger to himself or his patients. The physician making the report is immune from liability if the report is not made in bad faith or with malicious intent.

Mental health providers are, under certain circumstances, immune from civil liability where they take steps to protect third parties from harm by a patient. Providers are required to report or disclose the diagnosis of certain diseases, and are immune from liability for such reports or disclosures unless the provider acted with gross negligence or malicious intent. Prescribers are immune from liability resulting from a pharmacist's substitution of a drug product different from the drug product prescribed. Certain immunity is afforded to those providing free services to patients of a clinic unless the provider commits gross negligence or willful misconduct. Physicians who fail to report suspected child abuse or neglect with 72 hours of suspicion may be fined. Immunity is afforded to physicians who report suspected abuse in the absence of bad faith or malicious intent.

27. Uniform Claim and Referral Forms: §§ 38.2-322, -3407.4:1. No carrier may refuse to accept the standardized HCFA-1500 claim form, and no carrier that requires the use of CPT identifying codes shall refuse to use these identifying codes and listed modifiers. The SCC shall adopt a uniform referral form for certain managed care organizations which require referrals for a patient to receive consultation services.

28. Assignment: 38.2-3407.13. Newly adopted § 38.2-3407.13 addresses assignment of benefits only in the context of oral surgeons and dentists and states that all carriers must respect an assignment of benefits. No restriction on balance billing is included. Similar legislation applicable to all other providers was passed during the 1999 Session with a reenactment clause. This means it does not become law unless it is reenacted by the General Assembly next year. This legislation would prohibit balance billing in the context of an assignment. The Joint Commission on Health Care is expected to study the implications of the second law and report its findings to the General Assembly in advance of next year's Session.

29. Hospital Provisions: §§ 32.1-125.2, -135.2, -134.1; § 54.1-2413(A). A number of laws regulating hospitals may have managed care implications because hospitals often own or control managed care plans and because maintenance of staff privileges is often a requirement for physician participation.

Before referring a patient to a provider of outpatient items or services in which a hospital (or its affiliate) has an interest, the hospital must disclose to the patient in bold print that the items or services may be available from other suppliers in the community. No hospital shall knowingly and willfully offer or pay any remuneration to any practitioner for any referral. Separately, no hospital shall penalize a practitioner for complying with the Practitioner Self-Referral Act.

It is improper for a hospital to fail to act within 60 days on an application for medical staff membership or to deny or diminish privileges without stating the reason in writing to the physician. The reasons must be related to patient care or welfare, violation of rules of the hospital or staff, the objectives or efficient operations of the hospital, the applicant's character or competency, or misconduct in a hospital. A violation may result in loss of certification or licensure under § 32.1-135.

It would be helpful to physicians if, as other states have done, similar due process provisions could be added to the MCHIP statutes. The proposed MCHIP regulations appear to take a helpful step in that direction. See paragraph 8b.

30. Unprofessional Conduct: § 54.1-2914. This statute sets out a laundry list of offenses constituting unprofessional conduct by providers, including “[c]onducts his practice in a manner contrary to the standards of ethics in his branch of the healing arts.” It may be possible for a physician to use this sword as a shield to attempt to resist a carrier's implementation of payment or practice policies which can fairly be said to require the physician to compromise his or her ethical standards.

### Conclusion

This article is only an overview of certain Virginia laws which may be available to physicians and their patients who are dissatisfied with the actions or decisions of managed care plans. Although many believe additional regulation is needed, physicians and their advisors should be aware of the protections afforded by existing Virginia law when evaluating their rights in dealing with managed care plans.

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<sup>3</sup> Except as otherwise indicated, section references are to the Code of Virginia.

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