Senate Engrossed

FILED

JANICE K. BREWER
SECRETARY OF STATE

State of Arizona
Senate
Forty-seventh Legislature
Second Regular Session
2006

CHAPTER 293

SENATE BILL 1154

AN ACT

AMENDING SECTION 20-2510, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE INSURERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-2510, Arizona Revised Statutes, is amended to read:

20-2510. Health care insurers requirements; medical directors

A. A health care insurer that proposes to provide coverage of inpatient hospital and medical benefits, outpatient surgical benefits or any medical, surgical or health care service for residents of this state with utilization review of those benefits shall meet at least one of the following requirements:

1. Have a certificate issued pursuant to this chapter.

2. Be accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

3. Contract with a utilization review agent that has a certificate issued pursuant to this chapter.

4. Contract with a utilization review agent that is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

5. Provide to the director a signed and notarized statement that the health care insurer has submitted an application for accreditation to the utilization review accreditation commission or the national committee for quality assurance and is awaiting completion of the accreditation review process. On completion of the accreditation review process, the insurer shall provide to the director adequate proof that the insurer has been accredited. If the insurer is denied accreditation, within sixty days after the denial the insurer shall meet at least one of the requirements set forth in paragraph 1, 2, 3 or 4 of this subsection.

B. Except as provided in subsections C, ~~and~~ D AND E of this section, any direct denial of prior authorization of a service requested by a health care provider on the basis of medical necessity by a health care insurer shall be made in writing by a medical director who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17. The written denial shall include an explanation of why the treatment was denied, and the medical director who made the denial shall sign the written denial. The health care insurer shall send a copy of the written denial to the health care provider who requested the treatment. Health care insurers shall maintain copies of all written denials and shall make the copies available to the department for inspection during regular business hours. The medical director is responsible for all direct denials that are made on the basis of medical necessity. Nothing in this section prohibits a health care insurer from consulting with a licensed physician whose scope of practice may provide the health care insurer with a more thorough review of the medical necessity.

C. For determinations made pursuant to subsection B of this section, a dental service corporation as defined in section 20-822 or a prepaid dental plan organization as defined in section 20-1001 may use as a medical director either:

1. An individual who holds an active unrestricted license to practice dentistry in this state pursuant to title 32, chapter 11.

2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

D. For determinations made pursuant to subsection B of this section, an optometric service corporation may use as a medical director either:

1. An individual who holds an active unrestricted license to practice optometry in this state pursuant to title 32, chapter 16.

2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

E. FOR DETERMINATIONS MADE PURSUANT TO SUBSECTION B OF THIS SECTION, A HEALTH CARE INSURER MAY USE A CHIROPRACTOR LICENSED IN THIS STATE PURSUANT TO TITLE 32, CHAPTER 8 OR BY ANY REGULATORY BOARD IN ANOTHER STATE TO REVIEW ANY DIRECT DENIAL OF PRIOR AUTHORIZATION OF A CHIROPRACTIC SERVICE REQUESTED BY A CHIROPRACTOR ON THE BASIS OF MEDICAL NECESSITY.

APPROVED BY THE GOVERNOR MAY 19, 2006.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 19, 2006.