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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 977 Session of 1997

INTRODUCED BY VANCE, DRUCE, MICOZZIE, COLAFELLA, SAYLOR, WAUGH, CURRY, COLAIZZO, YOUNGBLOOD, SEMMEL, SCHRODER, HENNESSEY, TIGUE, ALLEN, GORDNER, NICKOL, KENNEY, MUNDY, E. Z. TAYLOR, TRICH, HARHART, D. W. SNYDER, MANDERINO, RUBLEY, CARONE, BUNT, ITKIN, TRUE, PESCI, STEELMAN, DeLUCA, CLYMER, CORNELL, JOSEPHS, BOSCOLA, STURLA, BARD, OLASZ, MILLER, L. I. COHEN, SATHER, GEORGE, O'BRIEN, FLEAGLE, BUXTON, STRITTMATTER, MICHLOVIC, STERN, TULLI, HALUSKA, BROWNE, OLIVER, McGILL, THOMAS, BEBKO-JONES, TRELLO, BELFANTI, GRUPPO, BOYES, ROSS, RAMOS, BARRAR, ZUG, ORIE, DENT, SEYFERT AND BAKER, MARCH 19, 1997

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, APRIL 20, 1998

AN ACT

~~Requiring certification of utilization review entities; providing for appeal processes for providers, for the disclosure of certain uniform information and for delivery of health care in a cost-effective manner.~~ <—

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PROVIDING FOR MANAGED HEALTH CARE UTILIZATION REVIEW; IMPOSING DUTIES ON MANAGED CARE ENTITIES; PROVIDING FOR DISCLOSURE, CIVIL IMMUNITY AND PENALTIES; AND CONFERRING POWERS AND DUTIES ON THE DEPARTMENT OF HEALTH AND THE INSURANCE DEPARTMENT. <——

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SECTION 18. EFFECTIVE DATE.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

~~Section 1. Short title.~~ <—

~~This act shall be known and may be cited as the Health Plan Accountability Act.~~

~~Section 2. Purposes.~~

~~The purposes of this act are to:~~

~~(1) Promote the delivery of health care in a cost-effective manner.~~

~~(2) Foster greater coordination among health care providers, patients and payers.~~

~~(3) Promote patient access to quality health care in a timely fashion.~~

~~(4) Safeguard patients by certifying the activities of utilization review entities.~~

~~(5) Provide sufficient information to providers regarding utilization review processes, criteria and the procedures for appealing utilization review determinations.~~

~~(6) Establish an appeals process that may be used by providers to appeal adverse utilization review determinations by utilization review entities.~~

~~(7) Establish minimum provider credentialing standards to be used by payers.~~

~~Section 3. Definitions.~~

~~The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:~~

~~"Accrediting body." A nationally recognized accrediting agency.~~

"Active clinical practice." A health care practitioner who practices clinical medicine on the average of not less than 20 hours per week.

"Clinical review criteria." The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a utilization review entity to evaluate the necessity and appropriateness of health care services delivered or proposed to be delivered.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Covered individual." An enrollee or an eligible dependent of an enrollee.

"Credentialing criteria." The standards used by a payer to evaluate the qualifications of a health care practitioner or health care facility to participate in the payer's provider network.

"Department." The Department of Health of the Commonwealth.

"Enrollee." An individual who has contracted for or who participates in coverage under:

(1) an insurance policy issued by a professional health service corporation, hospital plan corporation or a health and accident insurer;

(2) a contract issued by a health maintenance organization or a preferred provider organization; or

(3) other benefit programs providing payment, reimbursement or indemnification for the costs of health care for the covered individual.

"Health care facility." Any health care facility providing clinically related health services, including, but not limited to, a general or special hospital, including psychiatric

~~hospitals, rehabilitation hospitals, ambulatory surgical facilities, long-term care nursing facilities, cancer treatment centers using radiation therapy on an ambulatory basis and inpatient drug and alcohol treatment facilities.~~

~~"Health care insurer." Any entity operating under any of the laws listed in section 14.~~

~~"Health care practitioner." Any individual who is licensed, certified or otherwise regulated to practice health care under the laws of this Commonwealth, including, but not limited to, a physician, a dentist, a podiatrist, an optometrist, a psychologist, a physical therapist, a certified registered nurse practitioner, a registered nurse, a nurse midwife, a physician's assistant or a chiropractor.~~

~~"Integrated delivery system." A partnership, association, affiliation, corporation or other legal entity which enters into contractual, risk-sharing arrangements with health insurers to provide or arrange for the provision of health care services and assumes some responsibility for quality assurance, utilization review, provider credentialing and related functions and which assumes to some extent, through capitation reimbursement or other risk-sharing arrangement, the financial risk for provision of health care services to enrollees.~~

~~"Licensing authority." The licensing authority of the health insurers listed in section 14.~~

~~"Payer." Any entity operating under any of the laws listed in section 14 as well as any other entity employing, affiliated with or contracting with a utilization review entity or paying for credentialing activities.~~

~~"Provider network." The health care practitioners and health care facilities designated by a payer for enrollee use in~~

~~obtaining covered heath care services. This term shall not apply to broad-based networks that are primarily fee-for-service, indemnity arrangements with minimum participation requirements and limited utilization review procedures.~~

~~"Provider of record." The physician, licensed practitioner or health care facility identified to a utilization review entity or insurer as having prescribed, proposed to provide or provided health care services to a covered individual.~~

~~"Secretary." The Secretary of Health of the Commonwealth.~~

~~"Utilization review." A system for prospective, concurrent, retrospective review or case management of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual. The term does not include any of the following:~~

~~(1) requests for clarification of coverage, eligibility or benefits verification;~~

~~(2) a health care facility's or a health care practitioner's internal quality assurance or utilization review process unless such review results in a denial of payment, coverage or treatment; or~~

~~(3) refusal to contract with health care practitioners or health care facilities.~~

~~"Utilization review determination." The rendering of a decision based on utilization review that approves or denies either of the following:~~

~~(1) the necessity or appropriateness of the allocations of health care resources to a covered individual; or~~

~~(2) the provision or proposed provision of covered health care services to an enrollee.~~

~~"Utilization review entity." Any payer or any entity~~

~~performing utilization review while employed by, affiliated with, under contract with or acting on behalf of any of the following:~~

~~(1) an entity doing business in this Commonwealth;~~

~~(2) an integrated delivery system;~~

~~(3) a party that provides or administers health care benefits to citizens of this Commonwealth, including a health care insurer, self-insured plan, professional health service corporation, hospital plan corporation, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts to pay for the delivery of health care services or treatment in this Commonwealth; or~~

~~(4) the Commonwealth or any of its political subdivisions or instrumentalities.~~

~~The term shall not include entities conducting internal utilization review for health care facilities, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities, or private health care professional offices, unless the performance of such utilization review results in the denial of payment, coverage or treatment.~~

~~Section 4. Certification of utilization review entity.~~

~~(a) Certification required.--A utilization review entity may not conduct utilization review regarding services delivered or proposed to be delivered in this Commonwealth unless the entity is certified by the department to perform such services or unless the entity is an integrated delivery system whose utilization review standards have already been approved by the department and adopted for use by a certified utilization review~~

~~entity. A utilization review entity that has been operating in this Commonwealth prior to the effective date of this act may continue to conduct utilization review for not more than one year after the effective date of this act pending an initial certification determination by the department regarding that entity. The department shall grant certification to any utilization review entity that satisfies the utilization review standards included in sections 5 and 6.~~

~~(b) Renewal.--Certification shall be renewed every three years unless sooner revoked or suspended by the secretary.~~

~~(c) Accrediting bodies.--The department may rely on nationally recognized accrediting bodies to the extent the standards of the bodies are determined by the department to substantially meet or exceed the criteria in section 5 and if the entity agrees to the following:~~

~~(1) Direct the accrediting body to provide a copy of its findings to the department.~~

~~(2) Permit the department to verify compliance with standards not covered by the accrediting body.~~

~~(d) Fees.--The secretary is authorized to prescribe fees for initial application and renewal of certification. The fees shall not exceed the administrative costs of the certification process.~~

~~(e) Procedures.--Licensed health insurers are required to follow the standards and procedures contained in this act, but are not required to be separately certified as utilization review entities by the department.~~

~~Section 5. Utilization review standards.~~

~~(a) Requirements.--Utilization review entities providing services in this Commonwealth must satisfy all of the following~~

~~requirements:~~

~~(1) For the purpose of responding to inquiries concerning the entity's utilization review determinations:~~

~~(i) provide toll-free telephone access at least 40 hours each week during normal business hours;~~

~~(ii) maintain a telephone call answering service or recording system during hours other than normal business hours; and~~

~~(iii) respond to each telephone call left with the answering service or on the recording system within one business day after the call is left with respect to the review determination.~~

~~(2) Protect the confidentiality of individual medical records:~~

~~(i) as required by all applicable Federal and State laws and ensure that a covered individual's medical records and other confidential medical information obtained in the performance of utilization review are not improperly disclosed or redisclosed;~~

~~(ii) by only requesting medical records and other information which are reasonably necessary to make utilization review determination for the care under review; and~~

~~(iii) have mechanisms in place that allow a provider to verify that an individual requesting information on behalf of the organization is a legitimate representative of the organization.~~

~~(3) Unless required by law or court order, prevent third parties from obtaining a covered individual's medical records or confidential information obtained in the performance of~~

~~utilization review.~~

~~(4) Assure that personnel conducting utilization review shall have current licenses that are in good standing and without restrictions from a state health care professional licensing agency in the United States.~~

~~(5) Within one business day after receiving a request for an initial utilization review determination that includes all information reasonably necessary to complete the utilization review determination, notify the enrollee and the provider of record of the utilization review determination by mail or other means of communication.~~

~~(6) Include the following in the written notification of a utilization review determination denying coverage for an admission, service, procedure, medical supplies and equipment or a request for approval of continuing treatment for the condition involved in previously approved admissions, services or procedures, medical supplies and equipment:~~

~~(i) the principal reasons for the determination if the determination is based on medical necessity or the appropriateness of the admission, service, procedure, medical supplies and equipment, or extension of service; and~~

~~(ii) the description of the appeal procedure, including the name and telephone number of the person to contact in regard to an appeal and the deadline for filing an appeal.~~

~~(7) Ensure that initial adverse utilization review determination as to the necessity or appropriateness of an admission, service, procedure or medical supplies and equipment is made by a licensed physician or, if appropriate,~~

~~a psychologist.~~

~~(8) Ensure that on appeal all determinations not to certify an admission, service, procedure, medical supplies and equipment or extension of stay must be made by a licensed physician or, if appropriate, a psychologist in the same or similar general specialty as typically manages or recommends treatment for the medical condition, procedure or treatment. Further, no physician or psychologist who has been involved in prior reviews of the case under appeal may participate as the sole reviewer of a case under appeal.~~

~~(9) Provide a period of at least 24 hours following an emergency admission, service, procedure or medical supplies and equipment during which an enrollee or representative of an enrollee may notify the health care insurer and request approval or continuing treatment for the condition under review in the admission, extension of stay, service, procedure, medical supplies and equipment.~~

~~(10) Provide an appeals procedure satisfying the requirements set forth in this act.~~

~~(11) Disclose utilization review criteria to providers upon denial.~~

~~(b) Alternative practices.--Payers and providers may establish alternative utilization review standards, practices and procedures by contract that meet or exceed the requirements in subsection (a) and that are approved by the department.~~

~~Section 6. Utilization review decisions and internal appeals.~~

~~Payers that encourage or require enrollees to obtain all or designated covered services through a provider network shall conform to the following provisions:~~

~~(1) Notification of a prospective or concurrent~~

~~utilization review determination shall be communicated with the provider of record within one business day of the receipt of all information necessary to complete the review. For retrospective determinations, notice shall be given within 15 days.~~

~~(2) The utilization review entity shall maintain and make available a written description of the appeal procedure by which the provider of record may seek review of the determination to deny an admission, service, procedure, medical supplies and equipment or extension of stay.~~

~~(3) The internal appeals process shall be established by the utilization review entity and must include a reasonable time period of not less than 45 days following receipt of the written notification of the adverse determination within which an appeal must be filed to be considered.~~

~~(4) The utilization review entity shall render a determination of appeals of adverse determinations no later than 45 days from the date the appeal and all supporting documentation is filed.~~

~~(5) The utilization review entity shall provide for an expedited appeals process for emergency or life-threatening situations. Adjudication of expedited appeals shall be completed within 48 hours of the time the appeal is filed.~~

~~(6) Compensation to any person performing utilization review activities shall not contain incentives, direct or indirect, for that person to approve or deny coverage for admissions, services, procedures, medical supplies and equipment or extension of stays.~~

~~(7) The utilization review entity shall maintain records of written appeals and their resolution and shall provide~~

~~reports to their licensing authority or as requested by the department.~~

~~(8) The department may, in response to a written complaint by a provider, review the payer's adherence to the requirements of this act.~~

~~Section 7. External utilization review appeals.~~

~~The utilization review plan of utilization review entities or health care insurers must provide for independent external adjudication in cases where the second level of appeal to reverse an adverse determination is unsuccessful that adheres to the following provisions:~~

~~(1) The provider of record may initiate the external appeal within 60 days of the adverse determination by submitting written notice to the utilization review entity or health care insurer.~~

~~(2) The utilization review entity or health care insurer and the provider of record shall each select one competent arbitrator within 30 days from the date the appeal is initiated. The two selected arbitrators shall then select a competent third arbitrator. The arbitration shall take place in the county in which the appealing party resides or practices.~~

~~(3) At least one arbitrator shall be a licensed physician or, if appropriate, a psychologist, in active clinical practice in the same or similar specialty as typically manages or recommends treatment for the medical condition under review. The remaining arbitrators shall also be licensed health care practitioners.~~

~~(4) The arbitrators shall review the information considered by the health care insurer in reaching its~~

~~decision and any written submissions of the provider of record provided during the internal appeal process. The decision to hold a hearing or otherwise take evidence shall be within the sole discretion of a majority of the arbitrators.~~

~~(5) The written decision of any two arbitrators shall be issued no later than 30 days after receipt of all documentation necessary to rule upon the appeal and shall be binding upon each party.~~

~~(6) The arbitrators' fees and costs of the appeal shall be paid by the nonprevailing party.~~

~~(7) Written contracts between health care insurers and providers may provide for an alternative to the external appeal process as long as that contract or process has been approved by the department. In such cases, a provider may appeal to a physician committee appointed by the governing body of the utilization review entity or health care insurer. No physician serving on the committee to review such appeals may be an employee of the utilization review entity or health care insurer. The provider of record may present information supporting his or her position either in writing or by appearing before the committee in person to do so. The alternative appeals process must include time frames for initiating appeals, receiving written information, holding hearings and rendering final determinations. The committee's decision is the utilization review entity's health care insurer's final determination. If the decision is unfavorable to the provider of record or health care insurer, the provider of record or health care insurer may seek additional remedies in the appropriate court of jurisdiction, as a~~

matter of original jurisdiction pursuant to 42 Pa.C.S. § 761 (relating to original jurisdiction), to the extent such remedies are provided by law.

Section 8. Provider credentialing.

Payers that encourage or require enrollees to obtain all or designated covered services through a provider network shall conform to the following provisions:

(1) Payers must ensure that there are sufficient health care practitioners and health care facilities within a provider network to provide enrollees with access to quality patient care in a timely fashion.

(2) Payers shall consult with practicing physicians regarding the professional qualifications, specialty and geographic composition of the physician panel. The payer shall report the composition of its provider network, including the extent to which providers in the network are accepting new enrollees from the insurer, to its licensing authority every two years, or in response to significant changes in the provider network, or as otherwise required by the licensing authority.

(3) A payer shall select the participating health care practitioners and health care facilities for its provider network through a formal credentialing process that includes criteria and processes for initial selection, recredentialing and termination. The payer shall report the credentialing criteria and processes to its licensing authority every two years, or in response to significant changes in the criteria and/or processes, or as otherwise required by the licensing authority.

(4) A payer shall disclose to applicants and to

~~providers participating in its network all credentialing criteria and processes used by the payer and approved by the department or by a nationally recognized accrediting body. The proceedings, deliberations and records of a payer with respect to the credentialing of health care providers, however, shall be held in confidence and shall not be subject to discovery or entered into evidence in any civil action against a payer to the same degree that such deliberations, proceedings and records are protected under the act of July 20, 1974 (P.L.564, No.193), known as the Peer Review Protection Act.~~

~~(5) A payer shall not discriminate against patients with expensive medical conditions by excluding from its network health care practitioners with practices that include a substantial number of such patients and consistent with other credentialing criteria.~~

~~(6) A payer shall not exclude a health care practitioner or health care facility from its provider network because the practitioner or facility has advocated on behalf of a patient in a utilization appeal or another dispute with the plan over the provision of medical care.~~

~~(7) In the event a payer renders an adverse credentialing decision, the payer shall provide the affected health care practitioner or health care facility with written notice of the decision that includes a clear explanation of the basis for the decision.~~

~~Section 9. Uniform disclosure.~~

~~(a) Format.--The commissioner shall adopt a uniform format for the disclosure of the terms and conditions of health insurance plans.~~

~~(b) Contents.--The uniform format shall include, at a minimum, the following provisions:~~

~~(1) The benefits and any and all exclusions.~~

~~(2) Any and all enrollee coinsurance, copayments and deductibles.~~

~~(3) Any and all maximum benefit limitations.~~

~~(4) Any and all requirements or limitations regarding the choice of provider.~~

~~(5) Disclosure of any and all physician incentive plans.~~

~~(6) Enrollee satisfaction statistics.~~

~~(c) Mandatory use.--Payers shall make the information required by the commissioner available to purchasers and potential enrollees in the format adopted by the commissioner.~~

~~(d) Understandable terms.--The information shall be written in terms understandable to the general public.~~

~~Section 10. Penalties.~~

~~The department may impose a fine of up to but not more than $10,000 for each violation of this act. In addition, the department may deny, suspend, revoke or refuse to renew the certification of a utilization review entity or health care insurer that fails to satisfy the utilization review standards set forth in section 5 or that otherwise violates the provisions of this act. The utilization review entity or health care insurer shall be entitled to notice and the right to a hearing pursuant to 2 Pa.C.S. (relating to administrative law and procedure).~~

~~Section 11. Rulemaking.~~

~~The secretary and the commissioner are authorized to promulgate regulations to implement this act.~~

~~Section 12. Severability.~~

~~The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.~~

~~Section 13. Repeals.~~

~~All acts and parts of acts are repealed insofar as they are inconsistent with this act.~~

~~Section 14. Applicability.~~

~~This act shall apply to health care utilization review entities or health care insurers operating under any one of the following:~~

~~(1) Section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.~~

~~(2) Act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.~~

~~(3) Act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.~~

~~(4) 40 Pa.C.S. Ch.61 (relating to hospital plan corporations).~~

~~(5) 40 Pa.C.S. Ch.63 (relating to professional health services plan corporations) except for section 6324 (relating to rights of health service doctors).~~

~~(6) A fraternal benefit society charter.~~

~~(7) Any successor laws.~~

~~Section 15. Effective date.~~

~~This act shall take effect in 120 days.~~

SECTION 1. SHORT TITLE. <—

THIS ACT SHALL BE KNOWN AND MAY BE CITED AS THE MANAGED CARE

ACCOUNTABILITY ACT.

SECTION 2. PURPOSE.

THE PURPOSES OF THIS ACT ARE TO:

(1) PROMOTE THE DELIVERY OF ACCESSIBLE, QUALITY AND COST-EFFECTIVE HEALTH CARE IN A TIMELY FASHION IN THIS COMMONWEALTH.

(2) PROMOTE COOPERATION AMONG HEALTH CARE PROVIDERS, PATIENTS AND HEALTH CARE INSURERS.

(3) PROVIDE FOR THE CERTIFICATION OF AND STANDARDS TO BE USED BY UTILIZATION REVIEW ENTITIES.

(4) ESTABLISH A PROCESS FOR HEALTH CARE PROVIDERS TO APPEAL DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.

(5) REQUIRE THE ESTABLISHMENT, USE AND DISCLOSURE OF PROVIDER CREDENTIALING STANDARDS.

(6) REQUIRE UNIFORM FORMAT AND DISCLOSURE OF THE TERMS AND CONDITIONS OF HEALTH CARE INSURER CONTRACTS.

SECTION 3. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ACT SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"ACTIVE CLINICAL PRACTICE." THE PRACTICE OF CLINICAL MEDICINE BY A HEALTH CARE PRACTITIONER FOR AN AVERAGE OF NOT LESS THAN 20 HOURS PER WEEK.

"CLEAN CLAIM." AS DEFINED IN SECTION 1816(C)(2)(B)(I) OF THE SOCIAL SECURITY ACT (49 STAT. 648, 42 U.S.C. § 1395H(C)(2)(B)(I)) WHICH HAS NO DEFECT OR IMPROPRIETY. A DEFECT OR IMPROPRIETY UNDER THIS DEFINITION INCLUDES LACK OF REQUIRED SUBSTANTIATING DOCUMENTATION OR A PARTICULAR CIRCUMSTANCE REQUIRING SPECIAL TREATMENT WHICH PREVENTS TIMELY PAYMENTS FROM

BEING MADE ON THE CLAIM.

"CLINICAL REVIEW CRITERIA." WRITTEN SCREENING PROCEDURES, DECISION ABSTRACTS, CLINICAL PROTOCOLS AND PRACTICE GUIDELINES USED BY A UTILIZATION REVIEW ENTITY TO EVALUATE THE MEDICAL NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES DELIVERED OR PROPOSED TO BE DELIVERED.

"CONCURRENT UTILIZATION REVIEW." A REVIEW BY A UTILIZATION REVIEW ENTITY OF ALL NECESSARY SUPPORTING INFORMATION WHICH OCCURS DURING AN ENROLLEE'S HOSPITAL STAY OR COURSE OF TREATMENT AND WHICH RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR A HEALTH CARE SERVICE.

"CREDENTIALING CRITERIA." THE STANDARDS USED BY A MANAGED CARE ENTITY TO EVALUATE THE QUALIFICATIONS OF A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY TO PARTICIPATE IN THE MANAGED CARE ENTITY'S PROVIDER NETWORKS.

"DENIAL." A DETERMINATION BY A MANAGED CARE ENTITY OR UTILIZATION REVIEW ENTITY WHICH IS BASED UPON THE MEDICAL NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES COVERED UNDER THE TERMS AND CONDITIONS OF THE CONTRACT WHICH ARE PRESCRIBED, PROVIDED OR PROPOSED TO BE PROVIDED AND WHICH:

(1) DISAPPROVES PAYMENT FOR A REQUESTED HEALTH CARE SERVICE COMPLETELY;

(2) APPROVES THE PROVISION OF A REQUESTED HEALTH CARE SERVICE FOR A LESSER SCOPE OR DURATION THAN REQUESTED BY A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY; OR

(3) DISAPPROVES PAYMENT FOR THE PROVISION OF A REQUESTED HEALTH CARE SERVICE BUT APPROVES PAYMENT FOR THE PROVISION OF AN ALTERNATIVE HEALTH CARE SERVICE.

"DEPARTMENT." THE DEPARTMENT OF HEALTH OF THE COMMONWEALTH.

"EMERGENCY MEDICAL CONDITION." THE SUDDEN ONSET OF A MEDICAL

OR PSYCHIATRIC CONDITION WHICH MANIFESTS ITSELF BY ACUTE SYMPTOMS OF A SUFFICIENT SEVERITY OR SEVERE PAIN SUCH THAT A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN:

(1) PLACING THE HEALTH OF THE INDIVIDUAL OR, WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR HER UNBORN CHILD IN SERIOUS JEOPARDY;

(2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

(3) SERIOUS DYSFUNCTION OF A BODILY ORGAN OR PART.

"EMERGENCY HEALTH CARE SERVICES." HEALTH CARE SERVICES WHICH ARE FURNISHED BY A PROVIDER AS A RESULT OF AN EMERGENCY MEDICAL CONDITION.

"ENROLLEE." A POLICY HOLDER, SUBSCRIBER, COVERED PERSON OR OTHER INDIVIDUAL, INCLUDING A DEPENDENT, ENTITLED TO RECEIVE HEALTH CARE COVERAGE UNDER A MANAGED CARE ENTITY'S INSURANCE POLICY OR CONTRACT ISSUED IN THIS COMMONWEALTH.

"HEALTH CARE FACILITY." A FACILITY PROVIDING CLINICALLY RELATED HEALTH CARE SERVICES. THE TERM INCLUDES A GENERAL OR SPECIAL HOSPITAL, A PSYCHIATRIC HOSPITAL, A REHABILITATION HOSPITAL, AN AMBULATORY SURGICAL FACILITY, A LONG-TERM CARE FACILITY, A CANCER TREATMENT CENTER USING RADIATION THERAPY ON AN AMBULATORY BASIS, A BIRTHING CENTER, AN INPATIENT OR OUTPATIENT DRUG AND ALCOHOL TREATMENT FACILITY, A HOME HEALTH CARE FACILITY AND A HOSPICE FACILITY.

"HEALTH CARE PRACTITIONER." AN INDIVIDUAL WHO IS LICENSED, CERTIFIED OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES UNDER THE LAWS OF THIS COMMONWEALTH AND WHOSE LICENSE, CERTIFICATE OR AUTHORIZATION IS IN GOOD STANDING AND WITHOUT RESTRICTIONS FROM THE APPROPRIATE PROFESSIONAL LICENSING AGENCY.

"HEALTH CARE SERVICES." ANY TREATMENT, ADMISSION, PROCEDURE, SERVICE, MEDICAL SUPPLIES AND EQUIPMENT, CONTINUING TREATMENT OR EXTENSION OF A STAY, WHICH IS PRESCRIBED, PROVIDED OR PROPOSED TO BE PROVIDED BY A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY. THE TERM INCLUDES SERVICES COVERED UNDER THE TERMS AND CONDITIONS OF A MANAGED CARE PLAN CONTRACT.

"INTEGRATED DELIVERY SYSTEM." ANY PARTNERSHIP, ASSOCIATION, AFFILIATION, CORPORATION, LIMITED LIABILITY CORPORATION OR OTHER LEGAL ENTITY WHICH:

(1) ENTERS INTO CONTRACTUAL, RISK-SHARING ARRANGEMENTS WITH MANAGED CARE ENTITIES TO PROVIDE OR ARRANGE FOR THE PROVISION OF HEALTH CARE SERVICES;

(2) ASSUMES SOME RESPONSIBILITY FOR QUALITY ASSURANCE, UTILIZATION REVIEW, PROVIDER CREDENTIALING AND RELATED FUNCTIONS; AND

(3) ASSUMES TO SOME EXTENT, THROUGH CAPITATION REIMBURSEMENT OR OTHER RISK-SHARING ARRANGEMENT, THE FINANCIAL RISK FOR PROVISION OF HEALTH CARE SERVICES TO ENROLLEES.

"MANAGED CARE ENTITY." A COMPREHENSIVE HEALTH CARE PLAN WHICH INTEGRATES THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES, INCLUDING BEHAVIORAL HEALTH, TO ENROLLEES THROUGH A NETWORK, WITH PARTICIPATING PROVIDERS SELECTED TO PARTICIPATE ON THE BASIS OF SPECIFIC STANDARDS AND WHICH PROVIDES FINANCIAL INCENTIVES FOR ENROLLEES TO USE THE NETWORK PROVIDERS IN ACCORDANCE WITH THE PLAN'S PROCEDURES. THE TERM DOES NOT INCLUDE A NETWORK WHICH IS PRIMARILY FEE-FOR-SERVICE, INDEMNITY ARRANGEMENT WITH NO MANAGED CARE COMPONENT. THE TERM INCLUDES HEALTH CARE PLANS PROVIDED THROUGH A POLICY OR CONTRACT AUTHORIZED UNDER ANY OF THE FOLLOWING:

(1) SECTION 630 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(2) ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(3) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS).

(4) 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

(5) A FRATERNAL BENEFIT SOCIETY CHARTER.

(6) A CONTRACT WITH THE DEPARTMENT OF PUBLIC WELFARE TO PROVIDE MEDICAL ASSISTANCE ON A CAPITATED BASIS.

"PROSPECTIVE UTILIZATION REVIEW." A REVIEW BY A UTILIZATION REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION WHICH:

(1) RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR A HEALTH CARE SERVICE; AND

(2) OCCURS PRIOR TO THE DELIVERY OR PROVISION OF THE HEALTH CARE SERVICE.

"PROVIDER NETWORK." THE HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES DESIGNATED BY A MANAGED CARE ENTITY TO PROVIDE COVERED HEALTH CARE SERVICES TO AN ENROLLEE.

"PROVIDER." THE HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY THAT PRESCRIBES, PROVIDES OR PROPOSES TO PROVIDE A HEALTH CARE SERVICE TO AN ENROLLEE.

"RETROSPECTIVE UTILIZATION REVIEW." A REVIEW BY A UTILIZATION REVIEW ENTITY OF ALL NECESSARY SUPPORTING INFORMATION WHICH:

(1) RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR A HEALTH CARE SERVICE; AND

(2) OCCURS FOLLOWING DELIVERY OR PROVISION OF THE HEALTH

CARE SERVICE.

"UTILIZATION REVIEW." A SYSTEM OF PROSPECTIVE, CONCURRENT OR RETROSPECTIVE UTILIZATION REVIEW OR CASE MANAGEMENT PERFORMED BY A UTILIZATION REVIEW ENTITY OF THE MEDICAL NECESSITY AND APPROPRIATENESS OF COVERED HEALTH CARE SERVICES PRESCRIBED, PROVIDED OR PROPOSED TO BE PROVIDED TO AN ENROLLEE. THE TERM DOES NOT INCLUDE ANY OF THE FOLLOWING:

(1) REQUESTS FOR CLARIFICATION OF COVERAGE, ELIGIBILITY VERIFICATION OR BENEFITS VERIFICATION.

(2) AN INTERNAL QUALITY ASSURANCE OR UTILIZATION REVIEW PROCESS OF A PROVIDER UNLESS THE REVIEW RESULTS IN A DENIAL.

"UTILIZATION REVIEW ENTITY." AN ENTITY THAT PERFORMS UTILIZATION REVIEW ON BEHALF OF A MANAGED CARE ENTITY PROVIDING COVERAGE TO RESIDENTS OF THIS COMMONWEALTH.

SECTION 4. CERTIFICATION OF UTILIZATION REVIEW ENTITY.

(A) CERTIFICATION REQUIRED.--

(1) EXCEPT AS SET FORTH IN PARAGRAPH (2), A UTILIZATION REVIEW ENTITY MAY NOT CONDUCT UTILIZATION REVIEW REGARDING HEALTH CARE SERVICES DELIVERED OR PROPOSED TO BE DELIVERED IN THIS COMMONWEALTH UNLESS THE ENTITY IS CERTIFIED BY THE DEPARTMENT TO PERFORM A UTILIZATION REVIEW.

(2) PARAGRAPH (1) SHALL NOT APPLY TO A UTILIZATION REVIEW ENTITY OPERATING IN THIS COMMONWEALTH ON JULY 1, 1998, FOR ONE YEAR FOLLOWING THE EFFECTIVE DATE OF THIS SECTION.

(B) RENEWAL.--CERTIFICATION MUST BE RENEWED EVERY THREE YEARS UNLESS OTHERWISE SUSPENDED OR REVOKED BY THE DEPARTMENT.

(C) ACCREDITING BODIES.--THE DEPARTMENT MAY UTILIZE A NATIONALLY RECOGNIZED ACCREDITING BODY'S STANDARDS TO CERTIFY UTILIZATION REVIEW ENTITIES TO THE EXTENT THAT THE ACCREDITING BODY'S STANDARDS MEET OR EXCEED THE STANDARDS SET FORTH IN

SECTION 5 IF THE ENTITY AGREES TO DO ALL OF THE FOLLOWING:

(1) DIRECT THE ACCREDITING BODY TO PROVIDE A COPY OF ITS FINDINGS TO THE DEPARTMENT.

(2) PERMIT THE DEPARTMENT TO VERIFY COMPLIANCE WITH STANDARDS NOT ADDRESSED BY THE ACCREDITING BODY.

(D) STANDARD.--THE DEPARTMENT SHALL GRANT CERTIFICATION TO A UTILIZATION REVIEW ENTITY WHICH MEETS THE APPLICABLE REQUIREMENTS OF SECTIONS 5, 6, 7 AND 8.

(E) FEES.--THE DEPARTMENT MAY PRESCRIBE FEES FOR APPLICATION FOR AND RENEWAL OF CERTIFICATION. THE FEES SHALL REFLECT THE ADMINISTRATIVE COSTS OF CERTIFICATION.

(F) MANAGED CARE ENTITIES AND INTEGRATED DELIVERY SYSTEMS.--

(1) A MANAGED CARE ENTITY SHALL COMPLY WITH THE STANDARDS AND PROCEDURES OF THIS ACT, BUT IS NOT REQUIRED TO BE SEPARATELY CERTIFIED AS A UTILIZATION REVIEW ENTITY.

(2) AN INTEGRATED DELIVERY SYSTEM UNDER A CONTRACT WHICH HAS BEEN APPROVED BY THE DEPARTMENT IS NOT REQUIRED TO BE SEPARATELY CERTIFIED AS A UTILIZATION REVIEW ENTITY.

SECTION 5. UTILIZATION REVIEW OPERATIONAL STANDARDS.

(A) REQUIREMENTS.--UTILIZATION REVIEW ENTITIES PROVIDING SERVICES IN THIS COMMONWEALTH SHALL COMPLY WITH ALL OF THE FOLLOWING:

(1) RESPOND TO INQUIRIES RELATING TO THE ENTITY'S UTILIZATION REVIEW DETERMINATIONS BY:

(I) PROVIDING TOLL-FREE TELEPHONE ACCESS AT LEAST 40 HOURS PER WEEK DURING NORMAL BUSINESS HOURS;

(II) MAINTAINING A TELEPHONE CALL ANSWERING SERVICE OR RECORDING SYSTEM DURING HOURS OTHER THAN NORMAL BUSINESS HOURS; AND

(III) RESPONDING BY MAIL OR OTHER MEANS TO EACH

TELEPHONE CALL REGARDING A REVIEW DETERMINATION RECEIVED BY THE ANSWERING SERVICE OR RECORDING SYSTEM WITHIN ONE BUSINESS DAY AFTER THE RECEIPT OF THE CALL.

(2) PROTECT THE CONFIDENTIALITY OF INDIVIDUAL MEDICAL RECORDS BY:

(I) COMPLYING WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND PROFESSIONAL ETHICAL STANDARDS TO ENSURE THAT AN ENROLLEE'S MEDICAL RECORDS AND OTHER CONFIDENTIAL MEDICAL INFORMATION OBTAINED IN THE PERFORMANCE OF UTILIZATION REVIEW ARE NOT IMPROPERLY DISCLOSED OR REDISCLOSED;

(II) ONLY REQUESTING MEDICAL RECORDS AND OTHER INFORMATION WHICH ARE NECESSARY TO MAKE A UTILIZATION REVIEW DETERMINATION FOR THE HEALTH CARE SERVICES UNDER REVIEW;

(III) ADOPTING MECHANISMS TO ALLOW A PROVIDER OF RECORD TO VERIFY THAT AN INDIVIDUAL REQUESTING INFORMATION ON BEHALF OF THE MANAGED CARE ENTITY IS A LEGITIMATE REPRESENTATIVE OF THE ENTITY; AND

(IV) DEEMING A COMMONWEALTH OFFICIAL, WHO IS ACTING ON BEHALF OF A CONSUMER AND WHO REQUESTS IN WRITING SPECIFIC INFORMATION FROM THE MANAGED CARE ENTITY OR ITS AGENTS, TO HAVE THE CONSENT OF THE CONSUMER TO RELEASE THE INFORMATION SPECIFIC TO THE REQUEST.

(3) RENDER UTILIZATION REVIEW DECISIONS BASED ON THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE HEALTH CARE SERVICE BEING REVIEWED.

(4) PROVIDE AN APPEALS PROCESS CONSISTENT WITH THE PROVISIONS OF THIS ACT.

(5) MAINTAIN AND MAKE AVAILABLE A WRITTEN DESCRIPTION OF ALL APPEALS AND RELATED PROCEDURES BY WHICH A PROVIDER MAY

SEEK REVIEW OF A DENIAL.

(6) ENSURE THAT PERSONNEL CONDUCTING UTILIZATION REVIEW HAVE CURRENT LICENSES IN GOOD STANDING AND WITHOUT RESTRICTIONS FROM THE APPROPRIATE PROFESSIONAL LICENSING AGENCY.

(7) COMPLY WITH ALL TIME FRAMES SET FORTH IN THIS ACT.

(8) PROVIDE WRITTEN DENIALS TO INCLUDE:

(I) THE SPECIFIC CLINICAL CRITERIA AND THE PRINCIPAL REASONS FOR THE DECISION; AND

(II) A DESCRIPTION OF THE PROCEDURE BY WHICH THE PROVIDER MAY APPEAL A DENIAL, INCLUDING THE NAME AND TELEPHONE NUMBER OF THE PERSON TO CONTACT IN REGARD TO AN APPEAL AND THE DEADLINE FOR FILING AN APPEAL.

(9) MAINTAIN FOR NOT LESS THAN THREE YEARS A WRITTEN RECORD OF EACH UTILIZATION REVIEW DENIAL, INCLUDING A DETAILED JUSTIFICATION OF THE DENIAL AND THE NOTIFICATION TO THE PROVIDER AND THE ENROLLEE.

(10) NOTIFY THE PROVIDER OF RECORD OF THE SPECIFIC FACTS OR DOCUMENTS REQUIRED TO COMPLETE THE UTILIZATION REVIEW WITHIN 48 HOURS OF RECEIPT OF THE REQUEST FOR REVIEW IF THE UTILIZATION REVIEW ENTITY LACKS NECESSARY SUPPORTING INFORMATION.

(11) PROVIDE A PERIOD OF AT LEAST 24 HOURS FOLLOWING AN EMERGENCY HEALTH CARE SERVICE DURING WHICH THE PROVIDER, ENROLLEE OR ENROLLEE'S DESIGNEE MAY NOTIFY A MANAGED CARE ENTITY AND REQUEST THE APPROVAL FOR CONTINUATION OF HEALTH CARE SERVICES FOR THE CONDITION UNDER REVIEW.

(B) COMPENSATION.--COMPENSATION TO ANY PERSON PERFORMING UTILIZATION REVIEW ACTIVITIES MAY NOT CONTAIN INCENTIVES, DIRECT OR INDIRECT, FOR THE PERSON TO APPROVE OR DENY PAYMENT FOR THE

DELIVERY OR COVERAGE OF HEALTH CARE SERVICES.

(C) ALTERNATIVE RESOLUTION.--MANAGED CARE ENTITIES AND PROVIDERS MAY ESTABLISH BY CONTRACT ALTERNATIVE UTILIZATION REVIEW STANDARDS, PRACTICES AND PROCEDURES WHICH MEET OR EXCEED THE REQUIREMENTS OF SUBSECTION (A) AND ARE APPROVED BY THE DEPARTMENT.

SECTION 6. INITIAL UTILIZATION REVIEW DECISIONS.

(A) REVIEW.--AN INITIAL UTILIZATION REVIEW WHICH RESULTS IN A DENIAL MUST BE MADE BY A LICENSED PHYSICIAN.

(B) NOTIFICATION.--NOTIFICATION OF AN INITIAL UTILIZATION REVIEW DECISION SHALL BE MADE WITHIN THE FOLLOWING TIME FRAMES:

(1) A PROSPECTIVE UTILIZATION REVIEW DECISION SHALL BE COMMUNICATED TO THE PROVIDER AND, IN THE CASE OF A DENIAL, TO THE ENROLLEE WITHIN 48 HOURS OF THE RECEIPT OF ALL SUPPORTING INFORMATION NECESSARY TO COMPLETE THE REVIEW.

(2) A CONCURRENT UTILIZATION REVIEW DECISION SHALL BE COMMUNICATED TO THE PROVIDER AND, IN THE CASE OF A DENIAL, TO THE ENROLLEE WITHIN 24 HOURS OF THE RECEIPT OF ALL SUPPORTING INFORMATION NECESSARY TO COMPLETE THE REVIEW.

(3) A RETROSPECTIVE UTILIZATION REVIEW DECISION SHALL BE COMMUNICATED TO THE PROVIDER AND, IN THE CASE OF A DENIAL, TO THE ENROLLEE WITHIN 30 DAYS OF THE RECEIPT OF ALL SUPPORTING INFORMATION NECESSARY TO COMPLETE THE REVIEW.

SECTION 7. INTERNAL APPEALS.

A DENIAL MAY BE APPEALED BY THE PROVIDER, WITH THE CONSENT OF THE ENROLLEE, TO AN INTERNAL APPEALS PROCESS UNDER SECTION 5(A)(4). THE INTERNAL APPEALS PROCESS MUST DO ALL OF THE FOLLOWING:

(1) INCLUDE A TIME PERIOD OF 45 DAYS FOLLOWING RECEIPT OF THE WRITTEN NOTIFICATION OF DENIAL WITHIN WHICH AN APPEAL

MAY BE FILED. THE NOTIFICATION OF DENIAL MUST INCLUDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE ENTITY TO WHICH THE PROVIDER MAY APPEAL THE DENIAL.

(2) NOTIFY THE PROVIDER AND THE ENROLLEE OF A DECISION NO LATER THAN 45 DAYS FROM THE DATE THE APPEAL AND ALL NECESSARY SUPPORTING INFORMATION IS FILED.

(3) ENSURE THAT A DENIAL RESULTING FROM AN INTERNAL APPEAL UNDER THIS SECTION IS MADE BY A LICENSED PHYSICIAN IN THE SAME OR SIMILAR SPECIALTY WHICH TYPICALLY MANAGES OR CONSULTS ON THE HEALTH CARE SERVICES. THE PHYSICIAN WHO RENDERED AN INITIAL DENIAL MAY NOT RENDER A DECISION ON AN APPEAL OF THAT DENIAL.

(4) PROVIDE AN EXPEDITED INTERNAL APPEALS PROCESS FOR A SITUATION IN WHICH THE ENROLLEE'S LIFE OR HEALTH WOULD BE SERIOUSLY JEOPARDIZED OR THE ENROLLEE'S ABILITY TO REGAIN MAXIMUM FUNCTION WOULD BE JEOPARDIZED. THIS PARAGRAPH INCLUDES NOTIFICATION OF THE PROVIDER AND ENROLLEE WITHIN 48 HOURS OF THE TIME THE APPEAL WAS FILED.

(5) MAINTAIN RECORDS OF INTERNAL APPEALS AND THE RESULTING DETERMINATIONS FOR NOT LESS THAN THREE YEARS AND PROVIDE THE RECORDS TO THE DEPARTMENT UPON REQUEST.

SECTION 8. INDEPENDENT EXTERNAL REVIEW PROCESS.

(A) REQUIREMENTS.--A MANAGED CARE ENTITY SHALL ESTABLISH AN INDEPENDENT EXTERNAL REVIEW PROCESS TO WHICH A PROVIDER MAY APPEAL A DENIAL BY THE INTERNAL PROCESS. THE INDEPENDENT EXTERNAL REVIEW PROCESS MUST MEET THE FOLLOWING REQUIREMENTS:

(1) THE PROVIDER MAY INITIATE THE INDEPENDENT EXTERNAL REVIEW WITHIN 15 DAYS OF RECEIPT OF A DENIAL BY THE INTERNAL APPEALS PROCESS BY:

(I) SUBMITTING A WRITTEN NOTICE, INCLUDING ANY

MATERIAL JUSTIFICATION AND ALL NECESSARY SUPPORTING INFORMATION, TO THE MANAGED CARE ENTITY; AND

(II) NOTIFYING THE ENROLLEE AND THE DEPARTMENT THAT AN INDEPENDENT EXTERNAL REVIEW HAS BEEN REQUESTED.

(2) THE UTILIZATION REVIEW ENTITY WHICH CONDUCTED THE INTERNAL APPEAL SHALL FORWARD COPIES OF ALL WRITTEN DOCUMENTATION ASSOCIATED WITH THE DENIAL, INCLUDING ALL NECESSARY SUPPORTING INFORMATION, A SUMMARY OF APPLICABLE ISSUES, A STATEMENT OF THE UTILIZATION REVIEW ENTITY'S DECISION, THE CRITERIA USED AND THE CLINICAL REASONS FOR THE DECISION, TO THE INDEPENDENT EXTERNAL REVIEW ENTITY WITHIN 15 DAYS OF THE RECEIPT OF THE REQUEST FOR REVIEW. THE MANAGED CARE ENTITY SHALL NOTIFY THE PROVIDER OF THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE SELECTED INDEPENDENT REVIEW ENTITY.

(3) INDEPENDENT EXTERNAL REVIEW DECISIONS SHALL BE MADE BY:

(I) ONE OR MORE LICENSED PHYSICIANS IN ACTIVE CLINICAL PRACTICE OR IN THE SAME OR SIMILAR SPECIALTY WHICH TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE SERVICE UNDER REVIEW; OR

(II) ONE OR MORE PHYSICIANS CURRENTLY CERTIFIED BY A BOARD APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES OR THE AMERICAN BOARD OF OSTEOPATHIC SPECIALTIES, IN THE SAME OR SIMILAR SPECIALTY WHICH TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE SERVICE UNDER REVIEW.

(4) THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL EVALUATE AND ANALYZE THE CASE AND RENDER A WRITTEN DECISION TO THE MANAGED CARE ENTITY AND THE PROVIDER WITHIN 30 DAYS.

THE STANDARD OF REVIEW SHALL BE WHETHER THE DENIAL BY THE INTERNAL APPEAL WAS MEDICALLY NECESSARY AND APPROPRIATE. THE DECISION SHALL BE SUBJECT TO APPEAL TO A COURT OF COMPETENT JURISDICTION WITHIN 60 DAYS OF RECEIPT OF THE EXTERNAL REVIEW ENTITY'S WRITTEN DECISION. THERE SHALL BE A REBUTTABLE PRESUMPTION IN FAVOR OF THE DECISION OF THE INDEPENDENT EXTERNAL REVIEW ENTITY.

(5) THE MANAGED CARE ENTITY SHALL AUTHORIZE ANY COVERED HEALTH CARE SERVICE OR PAY ANY CLAIM DETERMINED TO BE MEDICALLY NECESSARY AND APPROPRIATE UNDER PARAGRAPH (4), WHETHER OR NOT AN APPEAL TO A COURT OF COMPETENT JURISDICTION HAS BEEN FILED. IF THE MANAGED CARE ENTITY FAILS TO AUTHORIZE THE HEALTH CARE SERVICE OR PAY THE CLAIM WITHIN 15 DAYS OF RECEIPT OF NOTICE OF APPROVAL BY THE INDEPENDENT EXTERNAL REVIEW ENTITY, INTEREST SHALL BE ASSESSED AT A RATE OF 10% PER YEAR, NOTWITHSTANDING THE 45-DAY PERIOD IN SECTION 12.

(6) ALL FEES AND COSTS RELATED TO AN INDEPENDENT EXTERNAL REVIEW SHALL BE PAID BY THE NONPREVAILING PARTY. THE PROVIDER AND THE UTILIZATION REVIEW ENTITY OR MANAGED CARE ENTITY SHALL EACH PLACE IN ESCROW AN AMOUNT EQUAL TO ONE-HALF OF THE ESTIMATED COSTS OF THE INDEPENDENT EXTERNAL REVIEW. THE ESCROW SHALL BE HELD BY THE INDEPENDENT EXTERNAL REVIEW ENTITY.

(B) CERTIFIED UTILIZATION REVIEW.--THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF CERTIFIED UTILIZATION REVIEW ENTITIES THAT MEET THE REQUIREMENTS OF THIS SECTION AND THAT ARE QUALIFIED TO PERFORM INDEPENDENT EXTERNAL REVIEWS. THE DEPARTMENT MAY REMOVE AN INDEPENDENT EXTERNAL REVIEW ENTITY FROM THE LIST IF THE DEPARTMENT DETERMINES THAT THE ENTITY IS INCAPABLE OF PERFORMING ITS RESPONSIBILITIES OR VIOLATES THIS

ACT.

(C) ASSIGNMENT.--

(1) THE DEPARTMENT SHALL RANDOMLY ASSIGN REQUESTS FOR AN INDEPENDENT EXTERNAL REVIEW TO THOSE CERTIFIED UTILIZATION REVIEW ENTITIES LISTED IN SUBSECTION (B) WITHIN ONE BUSINESS DAY OF RECEIVING A REQUEST PURSUANT TO SUBSECTION (A)(1).

(2) IF THE 8 HOURS DURING WHICH THE DEPARTMENT IS OPEN TO THE PUBLIC EXPIRE AND THE DEPARTMENT FAILS TO SELECT THE UTILIZATION REVIEW ENTITY AT RANDOM, THE MANAGED CARE ENTITY SHALL DESIGNATE THE UTILIZATION REVIEW ENTITY CERTIFIED UNDER SECTION 4 AND SUBSECTION (B) TO CONDUCT THE INDEPENDENT EXTERNAL REVIEW.

(3) THE DEPARTMENT SHALL REPORT ANNUALLY TO THE GENERAL ASSEMBLY ITS FINDINGS BASED ON INFORMATION IT RECEIVES PURSUANT TO SUBSECTION (D)(4). THE REPORT SHALL INCLUDE A SUMMARY OF ANY COMPLAINTS IT HAS RECEIVED CONCERNING ENTITIES LISTED UNDER THIS SECTION AND ANY CORRECTIVE ACTIONS IT HAS TAKEN AS A RESULT OF SUCH COMPLAINTS. THE DEPARTMENT SHALL MAKE ITS ANNUAL REPORT AVAILABLE TO THE PUBLIC.

(D) PROCEDURE.--THE INDEPENDENT EXTERNAL REVIEW ENTITY SHALL DO ALL OF THE FOLLOWING:

(1) MAIL WRITTEN ACKNOWLEDGMENT OF THE RECEIPT OF THE NOTICE OF APPEAL TO THE PROVIDER, THE MANAGED CARE ENTITY AND THE UTILIZATION REVIEW ENTITY WHICH PERFORMED THE INTERNAL APPEAL.

(2) REVIEW THE INFORMATION CONSIDERED BY THE ENTITIES WHICH CONDUCTED THE INITIAL UTILIZATION REVIEW AND THE INTERNAL APPEAL TO REACH A DECISION TO DENY PAYMENT FOR HEALTH CARE SERVICES AND ANY OTHER WRITTEN SUBMISSIONS BY THE PROVIDER.

(3) MAIL TO THE PROVIDER, THE UTILIZATION REVIEW ENTITY AND THE MANAGED CARE ENTITY A WRITTEN NOTICE DESCRIBING SPECIFIC UTILIZATION REVIEW CRITERIA AND THE PRINCIPAL REASONS FOR THE DENIAL OF PAYMENT FOR HEALTH CARE SERVICES BY THE INDEPENDENT EXTERNAL REVIEW ENTITY. NOTICE OF THE DECISION SHALL ALSO BE SENT TO THE ENROLLEE.

(4) REPORT TO THE DEPARTMENT THE NUMBER, TYPE AND DISPOSITION OF EACH APPEAL EVERY SIX MONTHS. THE REPORT SHALL INCLUDE THE NAMES OF THE PROVIDERS, UTILIZATION REVIEW ENTITIES AND MANAGED CARE ENTITIES INVOLVED AND WHETHER THE UTILIZATION REVIEW ENTITY WAS SELECTED AT RANDOM OR CHOSEN BY THE MANAGED CARE ENTITY.

(E) FEES.--FEES TO FILE FOR AN INDEPENDENT EXTERNAL REVIEW MAY NOT EXCEED FEES ESTABLISHED BY THE MEDICARE PROGRAM FOR SIMILAR CONSULTATIONS, UNLESS OTHERWISE AGREED BY THE PARTIES TO THE APPEAL AND THE INDEPENDENT EXTERNAL REVIEW ENTITY.

(F) ALTERNATIVE DISPUTE RESOLUTION.--WRITTEN CONTRACTS BETWEEN MANAGED CARE ENTITIES AND PROVIDERS MAY PROVIDE FOR AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM TO THE INDEPENDENT EXTERNAL REVIEW IF THE DEPARTMENT APPROVES THE CONTRACT. THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM MUST INCLUDE SPECIFIC TIME LIMITATIONS TO INITIATE APPEAL, RECEIVE WRITTEN INFORMATION, CONDUCT A HEARING AND RENDER A FINAL DECISION; PROVIDE FOR IMPARTIAL REVIEWERS THAT MEET THE REQUIREMENTS OF SECTION 5(A); AND REQUIRE THAT REVIEWERS BE LICENSED CONSISTENT WITH SUBSECTION (A)(3). A WRITTEN DECISION PURSUANT TO AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL BE FINAL AND BINDING ON ALL PARTIES.

(G) CONSUMER GRIEVANCES.--NOTHING IN THIS SECTION SHALL INTERFERE WITH AN ENROLLEE'S RIGHT TO ACCESS A CONSUMER

GRIEVANCE PROCESS.

(H) CONFIDENTIALITY.--THE PROCEEDINGS, DELIBERATIONS AND RECORDS OF A MANAGED CARE ENTITY REGARDING UTILIZATION REVIEW OF HEALTH CARE SERVICES SHALL BE CONFIDENTIAL AND MAY NOT BE SUBJECT TO DISCOVERY OR ENTERED INTO EVIDENCE IN ANY CIVIL ACTION WITH THE EXCEPTION OF APPEALS UNDER SUBSECTION (A)(4) AGAINST A MANAGED CARE ENTITY TO THE SAME DEGREE THAT SUCH INFORMATION IS PROTECTED BY THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS THE PEER REVIEW PROTECTION ACT. INDIVIDUALS SUPPLYING SUCH INFORMATION OR PARTICIPATING IN THEIR USE SHALL BE ENTITLED TO THE SAME IMMUNITIES AS PROVIDED UNDER THAT ACT.

SECTION 9. PARTICIPATING PROVIDERS.

(A) REQUIREMENTS.--A MANAGED CARE ENTITY SHALL DO ALL OF THE FOLLOWING:

(1) ENSURE THAT THERE ARE SUFFICIENT HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES WITHIN A PROVIDER NETWORK TO PROVIDE ENROLLEES WITH ACCESS TO QUALITY HEALTH CARE SERVICES IN A TIMELY FASHION.

(2) CONSULT WITH HEALTH CARE PRACTITIONERS IN ACTIVE CLINICAL PRACTICE REGARDING THE PROFESSIONAL QUALIFICATIONS, SPECIALTY AND GEOGRAPHIC COMPOSITION OF THE PROVIDER NETWORK.

(3) REPORT THE COMPOSITION OF ITS PROVIDER NETWORK, INCLUDING THE EXTENT TO WHICH PROVIDERS IN THE NETWORK ARE ACCEPTING NEW ENROLLEES, TO THE DEPARTMENT:

(I) EVERY TWO YEARS;

(II) AFTER SIGNIFICANT CHANGES IN THE PROVIDER NETWORK; AND

(III) AS OFTEN AS REQUIRED BY THE DEPARTMENT.

(B) PROHIBITIONS.--A MANAGED CARE ENTITY MAY NOT DISCRIMINATE AGAINST PATIENTS WITH EXPENSIVE MEDICAL CONDITIONS

BY EXCLUDING FROM ITS NETWORK HEALTH CARE PRACTITIONERS WITH PRACTICES WHICH INCLUDE A SUBSTANTIAL NUMBER OF SUCH PATIENTS, CONSISTENT WITH THE CRITERIA SET FORTH IN SECTION 10.

SECTION 10. PROVIDER CREDENTIALING.

(A) PROCESS.--

(1) A MANAGED CARE ENTITY SHALL ESTABLISH A FORMAL CREDENTIALING PROCESS TO ENROLL THE PARTICIPATING HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES FOR A PROVIDER NETWORK. THE PROCESS SHALL INCLUDE WRITTEN CRITERIA AND PROCESSES FOR INITIAL ENROLLMENT, RENEWAL, RESTRICTIONS AND TERMINATION. THE MANAGED CARE ENTITY SHALL REPORT ON THE ESTABLISHED CREDENTIALING CRITERIA AND PROCEDURES TO THE DEPARTMENT:

(I) EVERY TWO YEARS;

(II) AFTER SIGNIFICANT CHANGES IN THE CRITERIA OR PROCESS; AND

(III) AS OFTEN AS REQUIRED BY THE DEPARTMENT.

(2) THE CRITERIA AND PROCEDURES MUST BE APPROVED BY THE DEPARTMENT. THE DEPARTMENT MAY UTILIZE A NATIONALLY RECOGNIZED ACCREDITING BODY'S STANDARDS FOR PROVIDER CREDENTIALING.

(3) THE MANAGED CARE ENTITY'S COMPLIANCE WITH THE PURPOSES OF SECTION 2 SHALL BE MONITORED BY THE DEPARTMENT TO ENSURE COMPLIANCE.

(B) DISCLOSURE.--A MANAGED CARE ENTITY SHALL DISCLOSE ALL CREDENTIALING CRITERIA AND PROCEDURES TO HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES THAT APPLY TO PARTICIPATE OR ARE PARTICIPATING IN ITS NETWORK. THE PROCEEDINGS, DELIBERATIONS AND RECORDS OF A MANAGED CARE ENTITY REGARDING THE CREDENTIALING OF HEALTH CARE PROVIDERS SHALL BE

CONFIDENTIAL, MAY NOT BE SUBJECT TO DISCOVERY AND MAY NOT BE ENTERED INTO EVIDENCE IN A CIVIL ACTION AGAINST A MANAGED CARE ENTITY, TO THE SAME DEGREE THAT SUCH INFORMATION IS PROTECTED BY THE PEER REVIEW PROTECTION ACT. INDIVIDUALS SUPPLYING SUCH INFORMATION OR PARTICIPATING IN THEIR USE SHALL BE ENTITLED THE SAME IMMUNITIES AS PROVIDED UNDER THAT ACT.

(C) EXCLUSION PROHIBITED.--A MANAGED CARE ENTITY MAY NOT EXCLUDE OR TERMINATE A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY FROM ITS PROVIDER NETWORK BECAUSE THE PRACTITIONER OR FACILITY ADVOCATED FOR MEDICALLY APPROPRIATE HEALTH CARE; ADVOCATED ON BEHALF OF A PATIENT OR HEALTH CARE SERVICE IN ANY UTILIZATION REVIEW, APPEAL OR OTHER DISPUTE REGARDING THE PROVISION OF HEALTH CARE SERVICES; OR PROTESTED A DECISION, POLICY OR PRACTICE OF A MANAGED CARE ENTITY OR OTHER HEALTH INSURER.

(D) PROVIDER CONSCIENCE CLAUSE.--A MANAGED CARE ENTITY MAY NOT EXCLUDE, DISCRIMINATE AGAINST OR PENALIZE ANY PROVIDER FOR ITS REFUSAL TO ALLOW, PERFORM, PARTICIPATE IN OR REFER FOR HEALTH CARE SERVICES, WHEN SUCH REFUSAL OF THE PROVIDER IS BY REASON OF MORAL OR RELIGIOUS GROUNDS PROVIDED THAT PROVIDER MAKES AVAILABLE SUCH INFORMATION TO ENROLLEES OR, IF APPLICABLE, PROSPECTIVE ENROLLEES.

(E) WRITTEN DECISIONS.--IF A MANAGED CARE ENTITY DENIES CREDENTIALING OR RECREDENTIALING TO AN APPLICANT, THE MANAGED CARE ENTITY SHALL PROVIDE THE HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY WITH WRITTEN NOTICE OF THE DECISION TO DENY CREDENTIALING. THE NOTICE MUST INCLUDE A CLEAR EXPLANATION OF THE BASIS FOR THE DECISION.

SECTION 11. UNIFORM DISCLOSURE.

(A) FORMAT.--THE INSURANCE DEPARTMENT SHALL ADOPT A UNIFORM

FORMAT FOR THE DISCLOSURE TO ENROLLEES OF THE TERMS AND CONDITIONS OF HEALTH INSURANCE PLANS AND CONTRACTS TO PROVIDE HEALTH CARE SERVICES.

(B) CONTENTS.--THE UNIFORM FORMAT SHALL INCLUDE, AT A MINIMUM, THE FOLLOWING PROVISIONS WRITTEN IN TERMS UNDERSTANDABLE TO THE GENERAL PUBLIC:

(1) THE BENEFITS AND ANY AND ALL EXCLUSIONS.

(2) ALL ENROLLEE COINSURANCE, COPAYMENTS AND DEDUCTIBLES.

(3) ALL MAXIMUM BENEFIT LIMITATIONS.

(4) ALL REQUIREMENTS OR LIMITATIONS REGARDING THE CHOICE OF PROVIDER.

(5) DESCRIPTION OF ANY AND ALL RESTRICTIONS OR LIMITATIONS ON PRESCRIPTION DRUGS AND BIOLOGICALS, INCLUDING ANY PRIOR AUTHORIZATION OR OTHER REVIEW REQUIREMENTS.

(6) DISCLOSURE OF PROVIDER INCENTIVE PLANS.

(7) ENROLLEE SATISFACTION STATISTICS.

(C) MANDATORY USE.--MANAGED CARE ENTITIES SHALL USE THE FORMAT ADOPTED BY THE INSURANCE DEPARTMENT TO MAKE THE REQUIRED INFORMATION AVAILABLE TO PURCHASERS AND POTENTIAL ENROLLEES.

SECTION 12. PROMPT PAYMENT OF CLEAN CLAIMS.

(A) REQUIREMENTS.--A MANAGED CARE ENTITY SHALL PAY A CLEAN CLAIM SUBMITTED BY A PROVIDER WITHIN 45 DAYS OF A RECEIPT OF THE CLAIM. THE ENTITY SHALL BE DEEMED TO HAVE RECEIVED THE CLAIM AND DOCUMENTATION THREE BUSINESS DAYS AFTER BEING MAILED BY THE PROVIDER TO THE APPROPRIATE DEPARTMENT WITHIN THE ENTITY. CONTRACTUAL AGREEMENTS BETWEEN ENTITIES AND PROVIDERS SHALL MEET OR EXCEED THE REQUIREMENTS SET FORTH IN THIS SECTION.

(B) FAILURE TO PAY.--IF AN ENTITY FAILS TO MAKE PAYMENT UNDER SUBSECTION (A), INTEREST AT 10% PER ANNUM SHALL BE ADDED

TO THE AMOUNT OF THE CLAIM, BEGINNING ON THE DAY AFTER THE REQUIRED PAYMENT DATE AND ENDING ON THE DATE ON WHICH PAYMENT OF THE CLAIM IS MADE. INTEREST IMPOSED FOR FAILURE TO COMPLY WITH SUBSECTION (A) WHICH REMAINS UNPAID AT THE END OF ANY 30-DAY PERIOD SHALL BE ADDED TO THE PRINCIPAL; AND, THEREAFTER, INTEREST SHALL ACCRUE ON THE ADDED AMOUNT.

(C) ADMINISTRATIVE REMEDY.--THE INSURANCE COMMISSIONER SHALL INVESTIGATE A WRITTEN COMPLAINT FROM A HEALTH CARE PROVIDER CONCERNING A MANAGED CARE ENTITY'S COMPLIANCE WITH THIS SECTION. A VIOLATION OF THIS SECTION SHALL BE CONSIDERED AN UNFAIR INSURANCE PRACTICE AND BE SUBJECT TO THE PROCEDURES AND PENALTIES UNDER THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS THE UNFAIR INSURANCE PRACTICES ACT.

SECTION 13. INVESTIGATIONS AND PENALTIES.

(A) INVESTIGATION.--EXCEPT AS SET FORTH IN SECTION 12, THE DEPARTMENT SHALL INVESTIGATE A MANAGED CARE ENTITY'S COMPLIANCE WITH THIS ACT IN RESPONSE TO A WRITTEN COMPLAINT BY A HEALTH CARE PROVIDER.

(B) PENALTIES.--THE DEPARTMENT MAY IMPOSE AN ADMINISTRATIVE PENALTY OF UP TO $10,000 FOR EACH VIOLATION OF THIS ACT. IN ADDITION, THE DEPARTMENT MAY DENY, SUSPEND, REVOKE OR REFUSE TO RENEW THE CERTIFICATION OF A UTILIZATION REVIEW ENTITY THAT FAILS TO COMPLY WITH THE PROVISIONS OF THIS ACT. THIS SUBSECTION IS SUBJECT TO 2 PA.C.S. CH. 5 SUBCH. A (RELATING TO PRACTICE AND PROCEDURE OF COMMONWEALTH AGENCIES) AND CH. 7 SUBCH. A (RELATING TO JUDICIAL REVIEW OF COMMONWEALTH AGENCY ACTION).

SECTION 14. REGULATIONS.

THE DEPARTMENT AND INSURANCE DEPARTMENT SHALL PROMULGATE REGULATIONS NECESSARY TO IMPLEMENT THE PROVISIONS OF THIS ACT.

SECTION 15. EXCEPTIONS.

THIS ACT SHALL NOT APPLY TO ANY OF THE FOLLOWING:

(1) PEER REVIEW OR UTILIZATION REVIEW PERFORMED UNDER THE ACT OF JUNE 2, 1915 (P.L.736, NO.338), KNOWN AS THE WORKERS' COMPENSATION ACT.

(2) THE ACT OF JULY 1, 1937 (P.L.2532, NO.470), KNOWN AS THE WORKERS' COMPENSATION SECURITY FUND ACT.

(3) PEER REVIEW, UTILIZATION REVIEW OR MENTAL OR PHYSICAL EXAMINATIONS PERFORMED UNDER 75 PA.C.S. CH. 17 (RELATING TO FINANCIAL RESPONSIBILITY).

(4) THE FEE-FOR-SERVICE PROGRAMS OPERATED BY THE DEPARTMENT OF PUBLIC WELFARE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396 ET SEQ.).

SECTION 16. APPLICABILITY.

(A) PREEMPTION.--NOTHING IN THIS ACT SHALL REGULATE OR AUTHORIZE REGULATION WHICH WOULD BE INEFFECTIVE BY REASON OF THE STATE LAW PREEMPTION PROVISIONS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (PUBLIC LAW 93-406, 88 STAT. 829).

SECTION 17. DISCRIMINATION ON MORAL OR RELIGIOUS GROUNDS PROHIBITED.

NO PUBLIC INSTITUTION, PUBLIC OFFICIAL OR PUBLIC AGENCY MAY IMPOSE PENALTIES, TAKE DISCIPLINARY ACTION AGAINST, OR DENY OR LIMIT PUBLIC FUNDS, LICENSES, AUTHORIZATIONS, OR OTHER APPROVALS OR DOCUMENTS OF QUALIFICATION TO ANY PERSON, ASSOCIATION, OR CORPORATION:

(1) ATTEMPTING TO ESTABLISH A PLAN; OR

(2) OPERATING, EXPANDING OR IMPROVING AN EXISTING PLAN, BECAUSE THE PERSON, ASSOCIATION OR CORPORATION REFUSES TO PAY FOR OR ARRANGE FOR THE PAYMENT OF ANY PARTICULAR FORM OF HEALTH CARE SERVICES OR OTHER SERVICES OR SUPPLIES COVERED BY OTHER PLANS WHEN SUCH REFUSAL IS BY REASON OF OBJECTION

THERETO ON MORAL OR RELIGIOUS GROUNDS.

SECTION 18. EFFECTIVE DATE.

THIS ACT SHALL TAKE EFFECT IN 180 DAYS.