

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 225 Session of 2021

INTRODUCED BY PHILLIPS-HILL, MARTIN, J. WARD, MENSCH, COLLETT, MUTH, KANE, STEFANO, AUMENT, CAPPELLETTI, BAKER, BROOKS, BOSCOLA, HUTCHINSON, SABATINA, TOMLINSON, LAUGHLIN, MASTRIANO, SANTARSIERO AND KEARNEY, MARCH 18, 2021

SENATOR DiSANTO, BANKING AND INSURANCE, AS AMENDED, JUNE 23, 2021

AN ACT

1 ~~Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An <--~~
2 ~~act relating to insurance; amending, revising, and~~
3 ~~consolidating the law providing for the incorporation of~~
4 ~~insurance companies, and the regulation, supervision, and~~
5 ~~protection of home and foreign insurance companies, Lloyds-~~
6 ~~associations, reciprocal and inter insurance exchanges, and~~
7 ~~fire insurance rating bureaus, and the regulation and~~
8 ~~supervision of insurance carried by such companies,~~
9 ~~associations, and exchanges, including insurance carried by~~
10 ~~the State Workmen's Insurance Fund; providing penalties; and~~
11 ~~repealing existing laws," in quality healthcare~~
12 ~~accountability and protection, further providing for~~
13 ~~definitions, for responsibilities of managed care plans,~~
14 ~~providing for preauthorization standards and for~~
15 ~~preauthorization costs, further providing for continuity of~~
16 ~~care, providing for step therapy protocols, further providing~~
17 ~~for required disclosure, for operational standards and~~
18 ~~providing for preauthorization and adverse determinations,~~
19 ~~for appeals, for access requirements in service areas, for~~
20 ~~uniform preauthorization form, for preauthorization~~
21 ~~exemptions and for data collection and reporting; and making~~
22 ~~an editorial change.~~

23 AMENDING THE ACT OF MAY 17, 1921 (P.L.682, NO.284), ENTITLED "AN <--
24 ACT RELATING TO INSURANCE; AMENDING, REVISING, AND
25 CONSOLIDATING THE LAW PROVIDING FOR THE INCORPORATION OF
26 INSURANCE COMPANIES, AND THE REGULATION, SUPERVISION, AND
27 PROTECTION OF HOME AND FOREIGN INSURANCE COMPANIES, LLOYDS
28 ASSOCIATIONS, RECIPROCAL AND INTER-INSURANCE EXCHANGES, AND
29 FIRE INSURANCE RATING BUREAUS, AND THE REGULATION AND
30 SUPERVISION OF INSURANCE CARRIED BY SUCH COMPANIES,
31 ASSOCIATIONS, AND EXCHANGES, INCLUDING INSURANCE CARRIED BY

1 THE STATE WORKMEN'S INSURANCE FUND; PROVIDING PENALTIES; AND
2 REPEALING EXISTING LAWS," IN QUALITY HEALTHCARE
3 ACCOUNTABILITY AND PROTECTION, FURTHER PROVIDING FOR
4 DEFINITIONS AND FOR RESPONSIBILITIES OF MANAGED CARE PLANS,
5 PROVIDING FOR PREAUTHORIZATION REVIEW STANDARDS AND FOR
6 PREAUTHORIZATION COSTS, FURTHER PROVIDING FOR CONTINUITY OF
7 CARE, PROVIDING FOR STEP THERAPY, FURTHER PROVIDING FOR
8 REQUIRED DISCLOSURE AND FOR OPERATIONAL STANDARDS AND
9 PROVIDING FOR INITIAL REVIEW OF PREAUTHORIZATION REQUESTS AND
10 ADVERSE DETERMINATIONS, FOR PREAUTHORIZATION DENIAL
11 GRIEVANCES AND FOR ACCESS REQUIREMENTS IN SERVICE AREAS; AND
12 MAKING AN EDITORIAL CHANGE.

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

15 ~~Section 1. The General Assembly finds that:~~ <--

16 ~~(1) Preauthorization of medical treatment, testing and~~
17 ~~procedures was initially designed to reduce unnecessary cost~~
18 ~~placed on insurers, insureds and providers.~~

19 ~~(2) The process of preauthorization and the process to~~
20 ~~appeal a preauthorization decision has not been updated in 20~~
21 ~~years.~~

22 ~~(3) The current preauthorization process has become~~
23 ~~overly expansive, to the point where it is interfering with~~
24 ~~the patient provider relationship by inserting a third party~~
25 ~~into the treatment decision making process.~~

26 ~~(4) The basic minimum requirements of this act are~~
27 ~~necessary to ensure that the patient provider relationship~~
28 ~~remains paramount in making any decision on the course of~~
29 ~~treatment.~~

30 ~~Section 2. It is the intent of the General Assembly to~~
31 ~~create clear definitions, notice requirements and processes for~~
32 ~~the determination of authorizing insurance coverage for medical~~
33 ~~treatment, procedures and testing prior to the patient receiving~~
34 ~~the treatment, procedure and testing.~~

35 ~~Section 3. The definitions of "emergency service,"~~
36 ~~"enrollee," "grievance," "health care service," "prospective~~

1 ~~utilization review," "retrospective utilization review,"~~
2 ~~"utilization review" and "utilization review entity" in section~~
3 ~~2102 of the act of May 17, 1921 (P.L.682, No.284), known as The~~
4 ~~Insurance Company Law of 1921, are amended and the section is~~
5 ~~amended by adding definitions to read:~~

6 Section 2102. ~~Definitions. As used in this article, the~~
7 ~~following words and phrases shall have the meanings given to~~
8 ~~them in this section:~~

9 * * *

10 ~~"Administrative defect." Any deficiency, error, mistake or~~
11 ~~missing information other than medical necessity that serves as~~
12 ~~the basis of an adverse determination issued by a utilization~~
13 ~~review entity as justification to deny preauthorization.~~

14 ~~"Adverse determination." A decision made by a utilization~~
15 ~~review entity from a preauthorization request that:~~

16 ~~(1) the health care services furnished or proposed to an~~
17 ~~insured are not medically necessary or result from an~~
18 ~~administrative denial; or~~

19 ~~(2) denies, reduces or terminates benefit coverage.~~

20 ~~The term includes a decision to deny a step therapy exception~~
21 ~~request under section 2118. The term does not include a decision~~
22 ~~to deny, reduce or terminate services that are not covered for~~
23 ~~reasons other than their medical necessity or experimental or~~
24 ~~investigational nature.~~

25 * * *

26 ~~"Appeal." A formal request, either orally or in writing, to~~
27 ~~reconsider a determination not to authorize a health care~~
28 ~~service prior to the service being provided. This does not~~
29 ~~include a grievance filed under section 2161, relating to~~
30 ~~reconsideration of a decision made after coverage has been~~

1 ~~provided.~~

2 ~~"Appeal procedure." A formal process that permits an~~
3 ~~insured, attending physician or his designee, facility or health~~
4 ~~care practitioner on an insured's behalf to appeal an adverse~~
5 ~~determination rendered by the utilization review entity or its~~
6 ~~designee utilization review entity or agent.~~

7 ~~"Authorization." A determination by a utilization review~~
8 ~~entity that:~~

9 ~~(1) A health care service has been reviewed and, based on~~
10 ~~the information provided, satisfies the utilization review~~
11 ~~entity's requirements for medical necessity.~~

12 ~~(2) The health care service reviewed is a covered service.~~

13 ~~(3) Payment will be made for the health care service.~~

14 * * *

15 ~~"Clinical criteria." Policies, screening procedures,~~
16 ~~determination rules, determination abstracts, clinical~~
17 ~~protocols, practice guidelines and medical protocols that are~~
18 ~~specified in a written document available for peer to peer~~
19 ~~review by a peer within the same profession and specialty and~~
20 ~~subject to challenge by an insured, a provider or a provider~~
21 ~~organization when used as a basis to withhold preauthorization,~~
22 ~~deny or otherwise modify coverage and that is used by a~~
23 ~~utilization review entity to determine the medical necessity of~~
24 ~~health care services. The criteria shall:~~

25 ~~(1) Be based on nationally recognized standards.~~

26 ~~(2) Be developed in accordance with the current standards of~~
27 ~~national accreditation entities.~~

28 ~~(3) Reflect community standards of care.~~

29 ~~(4) Ensure quality of care and access to needed health care~~
30 ~~services.~~

1 ~~(5) Be evidence based or based on generally accepted expert~~
2 ~~consensus standards.~~

3 ~~(6) Be sufficiently flexible to allow deviations from norms~~
4 ~~when justified on a case by case basis.~~

5 ~~(7) Be evaluated and updated if necessary at least annually.~~

6 ~~"Clinical practice guidelines." A systematically developed~~
7 ~~statement to assist in decision making by health care providers~~
8 ~~and enrollees relating to appropriate health care for specific~~
9 ~~clinical circumstances and conditions.~~

10 * * *

11 ~~"Emergency service." Any health care service provided to an~~
12 ~~enrollee, including prehospital transportation or treatment by~~
13 ~~emergency medical services providers, after the sudden onset of~~
14 ~~a medical condition that manifests itself by acute symptoms of~~
15 ~~sufficient severity or severe pain such that a prudent layperson~~
16 ~~who possesses an average knowledge of health and medicine could~~
17 ~~reasonably expect the absence of immediate medical attention to~~
18 ~~result in:~~

19 ~~(1) placing the health of the enrollee or, with respect to a~~
20 ~~pregnant woman, the health of the woman or her unborn child in~~
21 ~~serious jeopardy;~~

22 ~~(2) serious impairment to bodily functions; or~~

23 ~~(3) serious dysfunction of any bodily organ or part.~~

24 ~~Emergency transportation and related emergency service provided~~
25 ~~by a licensed ambulance service shall constitute an emergency~~
26 ~~service.~~

27 ~~{"Enrollee." Any policyholder, subscriber, covered person or~~
28 ~~other individual who is entitled to receive health care services~~
29 ~~under a managed care plan.}~~

30 ~~"Expedited appeal." A formal request, either orally or in~~

1 ~~writing, to reconsider an adverse determination not to authorize~~
2 ~~emergency health care services or urgent health care services.~~

3 ~~"Final adverse determination." An adverse determination that~~
4 ~~has been upheld by a utilization review entity at the completion~~
5 ~~of the utilization review entity's internal appeals process.~~

6 ~~"Grievance." As provided in subdivision (i), a request by an~~
7 ~~[enrollee] insured or a health care provider, with the written~~
8 ~~consent of the [enrollee] insured, to have a managed care plan~~
9 ~~or utilization review entity reconsider a decision solely~~
10 ~~concerning the medical necessity and appropriateness of a health~~
11 ~~care service after the service has been provided to the insured.~~
12 ~~If the managed care plan is unable to resolve the matter, a~~
13 ~~grievance may be filed regarding the decision that:~~

14 ~~(1) disapproves full or partial payment for a requested~~
15 ~~health care service;~~

16 ~~(2) approves the provision of a requested health care~~
17 ~~service for a lesser scope or duration than requested; or~~

18 ~~(3) disapproves payment for the provision of a requested~~
19 ~~health care service but approves payment for the provision of an~~
20 ~~alternative health care service.~~

21 ~~The term [does] shall not include a complaint.~~

22 ~~* * *~~

23 ~~"Health care service." Any [covered] treatment, admission,~~
24 ~~procedure, test used to aid in diagnosis or the provision of the~~
25 ~~applicable treatment, pharmaceutical product, medical supplies~~
26 ~~and equipment or other services, including behavioral health[,]~~
27 ~~prescribed] or otherwise provided or proposed to be provided by~~
28 ~~a health care provider to an enrollee under a managed care plan~~
29 ~~contract.~~

30 ~~* * *~~

1 ~~"Medically necessary health care services." Health care~~
2 ~~services that a prudent health care provider would provide to a~~
3 ~~patient for the purpose of preventing, diagnosing or treating an~~
4 ~~illness, injury, disease or its symptoms in a manner that is:~~
5 ~~(1) in accordance with generally accepted standards of~~
6 ~~medical practice based on clinical criteria;~~
7 ~~(2) appropriate in terms of type, frequency, extent, site~~
8 ~~and duration pursuant to clinical criteria; and~~
9 ~~(3) not primarily for the economic benefit of the health~~
10 ~~plans and purchasers or for the convenience of the patient,~~
11 ~~treating physician or other health care provider.~~

12 ~~"Medication assisted treatment" or "MAT." The use of~~
13 ~~medications approved by the United States Food and Drug~~
14 ~~Administration, including methadone, buprenorphine, alone or in~~
15 ~~combination with naloxone, or naltrexone, in combination with~~
16 ~~counseling and behavioral therapies, to provide a comprehensive~~
17 ~~approach to the treatment of substance use disorders.~~

18 ~~"NCPDP SCRIPT Standard." The National Council for~~
19 ~~Prescription Drug 10 Programs SCRIPT Standard Version 201310,~~
20 ~~the most recent standard adopted by the Department of Health and~~
21 ~~Human Services or a subsequently related version, provided that~~
22 ~~the new version is backwards compatible to the current version~~
23 ~~adopted by the Department of Health and Human Services. The~~
24 ~~NCPDP SCRIPT Standard applies to the provision of pharmaceutical~~
25 ~~or pharmacological products.~~

26 ~~"Nonurgent health care service." A health care service~~
27 ~~provided to an enrollee that is not considered an emergency~~
28 ~~service or an urgent health care service.~~

29 * * *

30 ~~"Preauthorization" or "prior authorization." The process by~~

1 ~~which a utilization review entity managed care organization or~~
2 ~~health care insurer determines the medical necessity of~~
3 ~~otherwise covered health care services prior to authorizing~~
4 ~~coverage and the rendering of the health care services,~~
5 ~~including, but not limited to, preadmission review, pretreatment~~
6 ~~review, utilization and case management. The term includes a~~
7 ~~health insurer's or utilization review entity's requirement that~~
8 ~~an insured or health care practitioner notify the health insurer~~
9 ~~or utilization review agent prior to providing a health care~~
10 ~~service. This determination and any appeal therefrom shall be~~
11 ~~conducted prior to the delivery or provision of a health care~~
12 ~~service and result in a decision to approve or deny payment for~~
13 ~~the health care service.~~

14 * * *

15 [{"Prospective utilization review." A review by a utilization
16 review entity of all reasonably necessary supporting information
17 that occurs prior to the delivery or provision of a health care
18 service and results in a decision to approve or deny payment for
19 the health care service.}]

20 * * *

21 "Retrospective utilization [review."] review" or
22 "retrospective review." A review by a utilization review entity
23 of all reasonably necessary supporting information which occurs
24 following delivery or provision of a health care service and
25 results in a decision to approve or deny payment for the health
26 care service[.], but may not be used to review a decision to
27 approve payment for health care services through
28 preauthorization.

29 * * *

30 "Urgent health care service." A health care service deemed

1 ~~by a provider to require expedited preauthorization review in~~
2 ~~the event a delay may jeopardize life or health of the insured~~
3 ~~or a delay in treatment could:~~

4 ~~(1) negatively affect the ability of the insured to regain~~
5 ~~maximum function; or~~

6 ~~(2) subject the insured to severe pain that cannot be~~
7 ~~adequately managed without receiving the care or treatment that~~
8 ~~is the subject of the utilization review as quickly as possible.~~

9 ~~The term shall not include an emergency service or nonurgent~~
10 ~~health care service.~~

11 ~~"Utilization review." A system of prospective, concurrent or~~
12 ~~retrospective utilization review performed by a utilization~~
13 ~~review entity of the medical necessity and appropriateness of~~
14 ~~health care services prescribed, provided or proposed to be~~
15 ~~provided to an enrollee. The term includes preauthorization, but~~
16 ~~does not include any of the following:~~

17 ~~(1) Requests for clarification of coverage, eligibility or~~
18 ~~health care service verification.~~

19 ~~(2) A health care provider's internal quality assurance or~~
20 ~~utilization review process unless the review results in denial~~
21 ~~of payment for a health care service.~~

22 ~~"Utilization review entity." Any entity certified pursuant~~
23 ~~to subdivision (h) that performs utilization review on behalf of~~
24 ~~a managed care plan. The term includes:~~

25 ~~(1) an employer with employees in this Commonwealth who are~~
26 ~~covered under a health benefit plan or health insurance policy;~~

27 ~~(2) an insurer that writes health insurance policies,~~
28 ~~including preferred provider organizations defined in section~~
29 ~~630;~~

30 ~~(3) pharmacy benefits managers responsible for managing~~

1 ~~access of insureds to available pharmaceutical or~~
2 ~~pharmacological care;~~

3 ~~(4) any other individual or entity that provides, offers to~~
4 ~~provide or administers hospital, outpatient, medical or other~~
5 ~~health benefits to an individual treated by a health care~~
6 ~~provider in this Commonwealth under a policy, plan or contract;~~
7 ~~or~~

8 ~~(5) a health insurer if the health insurer performs~~
9 ~~utilization review.~~

10 Section 4. Section 2111 of the act is amended by adding
11 paragraphs to read:

12 Section 2111. Responsibilities of Managed Care Plans. A
13 managed care plan shall do all of the following:

14 * * *

15 ~~(14) Make updates to its enrollment eligibility information~~
16 ~~within thirty (30) days of receiving updated enrollment~~
17 ~~information. Updates in enrollment eligibility may occur due to~~
18 ~~new enrollments, coordination of benefits or termination of~~
19 ~~benefits. If a managed care plan fails to update eligibility~~
20 ~~information in a timely manner, the managed care plan may not~~
21 ~~deny payment due to enrollment information being inaccurate for~~
22 ~~a date of service if current eligibility information was~~
23 ~~available. In the event of a retroactive termination or a~~
24 ~~determination that an enrollee was ineligible for benefits, a~~
25 ~~health plan may recover any payments made in error within thirty~~
26 ~~(30) days of the date of service.~~

27 ~~(15) When establishing rules pertaining to the timely filing~~
28 ~~of health care provider claims, provide that a health care~~
29 ~~provider's filing requirement will commence based on the~~
30 ~~following, whichever occurs latest:~~

~~(i) the time of patient discharge; or~~
~~(ii) when authorization or approval is confirmed by the~~
~~managed care plan.~~

~~Section 5. The act is amended by adding sections to read:~~

~~Section 2114. Preauthorization Standards. (a) No later~~
~~than one hundred eighty (180) days after the effective date of~~
~~this section, preauthorization requests shall be accessible to~~
~~health care providers and accepted by insurers, managed care~~
~~organizations and utilization review organizations~~
~~electronically through a secure electronic transmission~~
~~platform. The electronic preauthorization requirements under~~
~~this subsection shall not apply:~~

~~(1) under circumstances when electronic transmission is not~~
~~available to be issued or received due to a temporary~~
~~technological or electrical failure and, in the instance of a~~
~~temporary technological failure, a practitioner shall, within~~
~~seventy two (72) hours, seek to correct any cause for the~~
~~failure that is reasonably within the practitioner's control.~~

~~(2) when a practitioner who or health care facility that~~
~~does not have either of the following:~~

~~(i) Internet access; or~~
~~(ii) an electronic health record system.~~

~~(b) NCPDP SCRIPT Standard shall be acceptable for~~
~~pharmaceutical or pharmacological care, subject to the terms and~~
~~limitations under subsection (a).~~

~~(c) Any restriction that a utilization review entity places~~
~~on the preauthorization of health care services shall be:~~

~~(1) based on the medical necessity of those services and on~~
~~clinical criteria;~~

~~(2) applied consistently; and~~

1 ~~(3) disclosed by the managed care plan or utilization review~~
2 ~~entity pursuant to section 2136.~~

3 ~~(d) Adverse determinations and final adverse determinations~~
4 ~~made by a utilization review entity or agent thereof shall be~~
5 ~~based on clinical criteria.~~

6 ~~(e) A utilization review entity shall not deny coverage of a~~
7 ~~health care service solely based on the grounds that the health~~
8 ~~care service does not meet clinical criteria.~~

9 ~~(f) Preauthorization shall not be required:~~

10 ~~(1) where a medication, including noncontrolled generic~~
11 ~~medication or procedure prescribed for a patient is customary~~
12 ~~and properly indicated or is a treatment for the clinical~~
13 ~~indication as supported by peer reviewed medical publications;~~
14 ~~or~~

15 ~~(2) for the provision of MAT for the treatment of an opioid~~
16 ~~use disorder.~~

17 ~~(f.1) A managed care plan may not deny preauthorization for~~
18 ~~a health care service for an insured currently managed with an~~
19 ~~established treatment regimen or for continuity of care. The~~
20 ~~continued care may not be subject to concurrent review if the~~
21 ~~treatment regimen or continuity of care follows from a previous~~
22 ~~preauthorization approval.~~

23 ~~(g) If a provider contacts a utilization review entity~~
24 ~~seeking preauthorization, a medically necessary health care~~
25 ~~service and the utilization review entity, through any agent,~~
26 ~~contractor, employe or representative informs the provider that~~
27 ~~preauthorization is not required for the particular service that~~
28 ~~is sought, coverage for the service shall be deemed approved.~~

29 ~~(h) No later than one hundred eighty (180) days after the~~
30 ~~effective date of this section, the payer shall accept and~~

1 ~~respond to preauthorization requests under the pharmacy benefit~~
2 ~~through a secure electronic transmission using the NCPDP SCRIPT~~
3 ~~Standard ePA transactions.~~

4 ~~Section 2115. Preauthorization Costs. (a) In the event~~
5 ~~that an insured is covered by more than one health plan that~~
6 ~~requires preauthorization:~~

7 ~~(1) If preauthorization for a health care service has~~
8 ~~been approved by a primary insurer, then a secondary insurer~~
9 ~~or defined benefits plan may not refuse payment for health~~
10 ~~care services solely on the basis that the procedures of the~~
11 ~~secondary insurer for preauthorization were not followed.~~

12 ~~(2) Nothing in this section shall be construed to~~
13 ~~preclude a secondary insurer or defined benefits plan from~~
14 ~~preauthorizing a health care service that may have been~~
15 ~~denied preauthorization by a primary insurer.~~

16 ~~(b) An appeal of an adverse determination or external review~~
17 ~~of a final adverse determination shall be provided without~~
18 ~~charge to the insured or insured's health care provider.~~

19 ~~Section 6. Section 2117 of the act is amended by adding~~
20 ~~subsections to read:~~

21 ~~Section 2117. Continuity of Care. * * *~~

22 ~~(g) If the appeal of an adverse determination of a~~
23 ~~preauthorization request concerns ongoing health care services~~
24 ~~that are being provided pursuant to an initially authorized~~
25 ~~admission or course of treatment, the health care services shall~~
26 ~~be continued to be paid and provided without liability to the~~
27 ~~insured or insured's health care provider until the latest of:~~

28 ~~(1) thirty (30) days following the insured or insured's~~
29 ~~health care provider's receipt of a notice of final adverse~~
30 ~~determination satisfying the requirements of this act, if the~~

~~1 decision on adverse determination has been appealed through an
2 external review proceeding;~~

~~3 (2) the duration of treatment; or~~

~~4 (3) sixty (60) days.~~

~~5 (h) The insured shall receive services for the longest
6 possible time calculated under this section.~~

~~7 (i) The insurer shall not be permitted to retroactively
8 review the decision to approve and provide health care services
9 through preauthorization, including preauthorizing for extending
10 the term or course of treatment.~~

~~11 (j) Notwithstanding any other provision of law, the insurer
12 shall not retroactively recover the cost of treatment either for
13 the initial period of treatment or the period of treatment
14 provided to the insured as part of the decision making process
15 to authorize coverage of additional treatment periods.~~

16 Section 7. The act is amended by adding a section to read:

17 ~~Section 2118. Step Therapy. (a) The following shall apply:~~

~~18 (1) Clinical review criteria used to establish a step
19 therapy protocol shall be based on clinical practice guidelines
20 that:~~

~~21 (i) Recommend that the prescription drugs be taken in the
22 specific sequence required by the step therapy protocol.~~

~~23 (ii) Are developed and endorsed by a multidisciplinary panel
24 of experts that manages conflicts of interest among the members
25 of the writing and review groups by:~~

~~26 (A) Requiring members to disclose any potential conflict of
27 interests with entities, including insurers, health plans and
28 pharmaceutical manufacturers and recuse themselves from voting
29 if the member has a conflict of interest.~~

~~30 (B) Using a methodologist to work with writing groups to~~

1 ~~provide objectivity in data analysis and ranking of evidence~~
2 ~~through the preparation of evidence tables and facilitating~~
3 ~~consensus.~~

4 ~~(C) Offering opportunities for public review and comments.~~

5 ~~(iii) Are based on high quality studies, research and~~
6 ~~medical practice.~~

7 ~~(iv) Are created by an explicit and transparent process~~
8 ~~that:~~

9 ~~(A) minimizes biases and conflicts of interest;~~

10 ~~(B) explains the relationship between treatment options and~~
11 ~~outcomes;~~

12 ~~(C) rates the quality of the evidence supporting~~
13 ~~recommendations; and~~

14 ~~(D) considers relevant patient subgroups and preferences.~~

15 ~~(v) Are continually updated through a review of new~~
16 ~~evidence, research and newly developed treatments.~~

17 ~~(2) In the absence of clinical guidelines that meet the~~
18 ~~requirements under paragraph (1), peer reviewed publications may~~
19 ~~be substituted.~~

20 ~~(3) When establishing a step therapy protocol, a utilization~~
21 ~~review agent shall also take into account the needs of atypical~~
22 ~~patient populations and diagnoses when establishing clinical~~
23 ~~review criteria.~~

24 ~~(4) An insurer, pharmacy benefit manager or utilization~~
25 ~~review organization shall:~~

26 ~~(i) upon written request, provide all specific written~~
27 ~~clinical review criteria relating to the particular condition or~~
28 ~~disease, including clinical review criteria relating to a step~~
29 ~~therapy protocol override determination; and~~

30 ~~(ii) make the clinical review criteria and other clinical~~

~~1 information available on its publicly accessible Internet
2 website and to a health care professional on behalf of an
3 insured upon written request.~~

~~4 (5) This subsection shall not be construed to require
5 insurers, health plans or the Commonwealth to set up a new
6 entity to develop clinical review criteria used for step therapy
7 protocols.~~

~~8 (b) The following shall apply:~~

~~9 (1) When coverage of a prescription drug for the treatment
10 of any medical condition is restricted for use by an insurer,
11 health plan or utilization review organization through the use
12 of a step therapy protocol, the patient and prescribing
13 practitioner shall have access to a clear, readily accessible
14 and convenient process to request a step therapy exception. An
15 insurer, health plan or utilization review organization may use
16 its existing medical exceptions process to satisfy this
17 requirement. The process shall be made easily accessible on the
18 publicly accessible Internet website of the insurer, health plan
19 or utilization review organization. An insurer, health plan or
20 utilization review organization must disclose all rules and
21 criteria related to the step therapy protocol upon request to
22 all prescribing practitioners, including the specific
23 information and documentation that must be submitted by a
24 prescribing practitioner or patient to be considered a complete
25 exception request.~~

~~26 (2) A step therapy exception shall be granted if:~~

~~27 (i) The required prescription drug is contraindicated or
28 will likely cause an adverse reaction by or physical or mental
29 harm to the patient.~~

~~30 (ii) The required prescription drug is expected to be~~

1 ~~ineffective based on the known clinical characteristics of the~~
2 ~~patient and the known characteristics of the prescription drug~~
3 ~~regimen.~~

4 ~~(iii) The patient has tried the required prescription drug~~
5 ~~while under the patient's current or previous health insurance~~
6 ~~or health benefit plan, or another prescription drug in the same~~
7 ~~pharmacologic class or with the same mechanism of action, and~~
8 ~~the prescription drug was discontinued due to lack of efficacy~~
9 ~~or effectiveness, diminished effect or an adverse event.~~

10 ~~(iv) The required prescription drug is not in the best~~
11 ~~interest of the patient, based on medical necessity.~~

12 ~~(v) The patient is stable on a prescription drug selected by~~
13 ~~the patient's health care provider for the medical condition~~
14 ~~under consideration while on a current or previous health~~
15 ~~insurance or health benefit plan.~~

16 ~~(3) Upon the granting of a step therapy exception, the~~
17 ~~insurer, health plan or utilization review organization shall~~
18 ~~authorize coverage for the prescription drug prescribed by the~~
19 ~~patient's treating health care provider.~~

20 ~~(4) The insurer, health plan or utilization review~~
21 ~~organization shall grant or deny a step therapy exception~~
22 ~~request or an appeal within seventy two (72) hours of receipt.~~
23 ~~The following shall apply:~~

24 ~~(i) In cases where exigent circumstances exist, an insurer,~~
25 ~~health plan or utilization review organization shall respond~~
26 ~~within twenty four (24) hours of receipt.~~

27 ~~(ii) If a request for a step therapy override exception is~~
28 ~~incomplete or additional clinically relevant information is~~
29 ~~required, the insurer, health plan or utilization review~~
30 ~~organization shall notify the prescribing practitioner within~~

1 ~~seventy two (72) hours of submission, or twenty four (24) hours~~
2 ~~in exigent circumstances, what additional or clinically relevant~~
3 ~~information is required in order to approve or deny the step~~
4 ~~therapy exception request or appeal under this section.~~

5 ~~(iii) Once the requested information is submitted, the~~
6 ~~applicable time period to grant or deny a step therapy exception~~
7 ~~request or appeal shall apply.~~

8 ~~(iv) Should a determination or request for incomplete or~~
9 ~~clinically relevant information by an insurer, health plan or~~
10 ~~utilization review organization not be received by the~~
11 ~~prescribing practitioner within the time allotted, the exception~~
12 ~~or appeal shall be deemed granted.~~

13 ~~(v) In the event of a denial, the insurer, health plan or~~
14 ~~utilization review organization must inform the patient of a~~
15 ~~potential appeal process.~~

16 ~~(5) Any step therapy exception under this subsection shall~~
17 ~~be eligible for appeal by an insured.~~

18 ~~(6) This subsection shall not be construed to prevent:~~

19 ~~(i) An insurer, health plan or utilization review~~
20 ~~organization from requiring a patient to try an AB rated generic~~
21 ~~equivalent or interchangeable biological product, as defined in~~
22 ~~42 U.S.C. § 262(i)(3) (relating to regulation of biological~~
23 ~~products), unless the requirement meets any of the criteria~~
24 ~~under this subsection for a step therapy exception request,~~
25 ~~prior to providing coverage for the equivalent branded~~
26 ~~prescription drug;~~

27 ~~(ii) An insurer, health plan or utilization review~~
28 ~~organization from requiring a pharmacist to effect substitutions~~
29 ~~of prescription drugs consistent with the laws of this~~
30 ~~Commonwealth.~~

1 ~~(iii) A health care provider from prescribing a prescription~~
2 ~~drug that is determined to be medically appropriate.~~

3 ~~(c) Notwithstanding any provision of law to the contrary,~~
4 ~~the Insurance Department shall promulgate any regulations~~
5 ~~necessary to enforce this section.~~

6 ~~(d) An insurer, health plan or a utilization review~~
7 ~~organization shall annually report to the Insurance Department,~~
8 ~~in a format prescribed by the Insurance Department:~~

9 ~~(i) the number of step therapy exception requests received~~
10 ~~by exception;~~

11 ~~(ii) the type of health care providers or the medical~~
12 ~~specialties of the health care providers submitting step therapy~~
13 ~~exception requests;~~

14 ~~(iii) the number of step therapy exception requests by~~
15 ~~exception that were denied and the reasons for the denials;~~

16 ~~(iv) the number of step therapy exception requests by~~
17 ~~exception that were approved;~~

18 ~~(v) the number of step therapy exception requests by~~
19 ~~exception that were initially denied and then appealed;~~

20 ~~(vi) the number of step therapy exception requests by~~
21 ~~exception that were initially denied and then subsequently~~
22 ~~reversed by internal appeals or external reviews; and~~

23 ~~(vii) the medical conditions for which patients are granted~~
24 ~~exceptions due to the likelihood that switching from the~~
25 ~~prescription drug will likely cause an adverse reaction by or~~
26 ~~physical or mental harm to the insured.~~

27 ~~(e) As used in this section, the following words and phrases~~
28 ~~shall have the meanings given to them in this subsection unless~~
29 ~~the context clearly indicates otherwise:~~

30 ~~"Clinical practice guidelines." A systematically developed~~

~~1 statement to assist decision making by health care providers and
2 patient decisions about appropriate healthcare for specific
3 clinical circumstances and conditions.~~

~~4 "Clinical review criteria." The written screening
5 procedures, decision abstracts, clinical protocols and practice
6 guidelines used by an insurer, health plan or utilization review
7 organization to determine the medical necessity and
8 appropriateness of healthcare services.~~

~~9 "Medically necessary." Health services and supplies that
10 under the applicable standard of care are appropriate:~~

~~11 (1) to improve or preserve health, life or function;~~

~~12 (2) to slow the deterioration of health, life or
13 function; or~~

~~14 (3) for the early screening, prevention, evaluation,
15 diagnosis or treatment of a disease, condition, illness or
16 injury.~~

~~17 "Step therapy exception." When a step therapy protocol
18 should be overridden in favor of immediate coverage of the
19 health care provider's selected prescription drug.~~

~~20 "Step therapy protocol." A protocol, policy or program that
21 establishes the specific sequence in which prescription drugs
22 for a specified medical condition and medically appropriate for
23 a particular patient are covered by an insurer or health plan.~~

~~24 "Utilization review organization." An entity that conducts
25 utilization review, other than an insurer or health plan
26 performing utilization review for its own health benefit plans.~~

~~27 Section 8. Article XXI, Subdivision (f) subheading of the
28 act is amended to read:~~

~~29 (f) Information for Enrollees and Health Care Providers.~~

~~30 Section 9. Section 2136 of the act is amended by adding a~~

1 subsection to read:

2 Section 2136. ~~Required Disclosure. * * *~~

3 ~~(c) If a utilization review entity intends to implement a~~
4 ~~new preauthorization requirement or restriction or amend an~~
5 ~~existing requirement or restriction, the utilization review~~
6 ~~entity shall provide contracted health care providers and~~
7 ~~insureds with written notice of the new or amended requirement~~
8 ~~or amendment not less than sixty (60) days before the~~
9 ~~requirement or restriction is implemented. The notice shall be~~
10 ~~in writing which may be satisfied by any of the following:~~

11 ~~(1) certified mail return receipt requested;~~

12 ~~(2) electronic mail read receipt requested;~~

13 ~~(3) publication on the publicly accessible Internet~~
14 ~~website of the insurer with an electronic mail message to~~
15 ~~providers and insureds that identifies the location of the~~
16 ~~publication on the website;~~

17 ~~(4) web exchange, provided that an electronic mail~~
18 ~~message on how to access the web exchange is sent to the~~
19 ~~providers and insured; or~~

20 ~~(5) any other contractually agreed upon method,~~
21 ~~specifying the details of the communication which include~~
22 ~~some proof of receipt by the providers and insureds.~~

23 Section 10. ~~Section 2152(a)(4) and (6) of the act are~~
24 ~~amended and the section is amended by adding subsections to~~
25 ~~read:~~

26 Section 2152. ~~Operational Standards. (a) A utilization~~
27 ~~review entity shall do all of the following:~~

28 * * *

29 ~~(4) Conduct utilization reviews based on the medical~~
30 ~~necessity and appropriateness of the health care service being~~

1 ~~reviewed and provide notification within the following time~~
2 ~~frames:~~

3 ~~(i) A prospective utilization review decision shall be~~
4 ~~communicated within two (2) business days of the receipt of all~~
5 ~~supporting information reasonably necessary to complete the~~
6 ~~review.~~

7 ~~(ii) A concurrent utilization review decision shall be~~
8 ~~communicated within one (1) business day of the receipt of all~~
9 ~~supporting information reasonably necessary to complete the~~
10 ~~review.~~

11 ~~(iii) A retrospective utilization review decision shall be~~
12 ~~communicated within thirty (30) days of the receipt of all~~
13 ~~supporting information reasonably necessary to complete the~~
14 ~~review.~~

15 ~~(iv) A utilization review entity shall allow an insured and~~
16 ~~the insured's health care provider a minimum of one (1) business~~
17 ~~day following an inpatient admission pursuant to an emergency~~
18 ~~health care service or urgent health care service to notify the~~
19 ~~utilization review entity of the admission and any health care~~
20 ~~services performed.~~

21 * * *

22 ~~(6) Provide all decisions in writing to include the basis~~
23 ~~and clinical rationale for the decision. For adverse~~
24 ~~determinations of preauthorization decisions, a utilization~~
25 ~~review entity shall provide all decisions to the insured and the~~
26 ~~insured's health care provider, which decisions shall also~~
27 ~~include instructions concerning how an appeal may be perfected.~~
28 ~~Utilization review entities may not retroactively review the~~
29 ~~medical necessity of a preauthorization that has been previously~~
30 ~~approved or granted.~~

1 * * *

2 ~~(9) Post to the utilization review entity's publicly~~
3 ~~accessible Internet website:~~

4 ~~(i) A current list of services and supplies requiring~~
5 ~~preauthorization.~~

6 ~~(ii) Written clinical criteria for preauthorization~~
7 ~~decisions.~~

8 ~~(10) Ensure that a preauthorization shall be valid for no~~
9 ~~less than one hundred eighty (180) days or the duration of~~
10 ~~treatment, whichever is greater, from the date the health care~~
11 ~~provider receives the preauthorization so long as the insured is~~
12 ~~a member of the plan. A duration of less than one hundred and~~
13 ~~eighty (180) days may be approved upon an agreement between a~~
14 ~~provider and payer.~~

15 ~~(11) When performing preauthorization, only request copies~~
16 ~~of medical records if a difficulty develops in determining the~~
17 ~~medical necessity of a health care service. In that case, the~~
18 ~~utilization review agent may only request the necessary and~~
19 ~~relevant sections of the medical record.~~

20 ~~(12) Not deny preauthorization nor delay preauthorization~~
21 ~~for administrative defects. In the event an administrative~~
22 ~~defect is discovered, a managed care plan shall allow a health~~
23 ~~care provider the opportunity to remedy the administrative~~
24 ~~defect within thirty (30) days of receiving notice.~~

25 * * *

26 ~~(e) Failure by a utilization review entity to comply with~~
27 ~~deadlines and other requirements specified for preauthorization~~
28 ~~shall result in the health care service subject to review to be~~
29 ~~deemed preauthorized and paid by the managed care plan.~~

30 ~~(f) A utilization review entity shall approve claims for~~

~~1 health care services for which a preauthorization was required
2 and received from the managed care plan prior to the rendering
3 of the health care services, unless one of the following occurs:~~

~~4 (1) The enrollee was not eligible for coverage at the time
5 the health care service was rendered. A managed care plan may
6 not deny payment for a claim on this basis if the enrollee's
7 coverage was retroactively terminated more than one hundred
8 twenty (120) days after the date of service, provided the claim
9 is submitted timely. If the claim is submitted after the timely
10 filing deadline, the managed care plan shall have no more than
11 thirty (30) days after the claim is received to deny the claim
12 on the basis the enrollee was not eligible for coverage on the
13 date of the health care service.~~

~~14 (2) The preauthorization was based on materially inaccurate
15 or incomplete information provided by the enrollee, the
16 enrollee's designee or the health care provider, such that if
17 the correct or complete information had been provided, the
18 preauthorization would not have been granted.~~

~~19 (3) There is a reasonable basis supported by material facts
20 available for review that the enrollee, the enrollee's designee
21 or the health care provider has engaged in fraud or abuse.~~

~~22 Section 11. The act is amended by adding sections to read:~~

~~23 Section 2161.1. Preauthorization and Adverse
24 Determinations. (a) A utilization review entity shall ensure
25 that:~~

~~26 (1) Preauthorization is made by a qualified licensed health
27 care provider who has knowledge of the items, services,
28 products, tests or procedures submitted for preauthorization.~~

~~29 (2) Adverse determinations are made by a physician. The
30 reviewing physician must possess a current and valid~~

1 ~~nonrestricted license to practice medicine in this Commonwealth~~
2 ~~and be board certified. The insurer shall make available a~~
3 ~~physician in a like specialty if the review requires a peer to~~
4 ~~peer review in the specialty or subspecialty or a review is~~
5 ~~requested by the submitting provider. A utilization review~~
6 ~~entity may seek approval from the Insurance Commissioner to use~~
7 ~~a reviewing physician that is not board certified due to~~
8 ~~unavailability or difficulty in finding a board certified~~
9 ~~reviewing physician in a given specialty. The Insurance~~
10 ~~Commissioner shall develop a form and parameters for the~~
11 ~~requests and shall transmit all requests as notices to the~~
12 ~~Legislative Reference Bureau for publication in the Pennsylvania~~
13 ~~Bulletin. The Insurance Commissioner shall provide at least ten~~
14 ~~(10) days for comment before rendering a decision, which~~
15 ~~decision shall be transmitted to the Legislative Reference~~
16 ~~Bureau as a separate notice for publication in the Pennsylvania~~
17 ~~Bulletin.~~

18 ~~(b) Notification of a preauthorization shall be accompanied~~
19 ~~by a unique preauthorization number and indicate:~~

20 ~~(1) The specific health care services preauthorized.~~

21 ~~(2) The next date for review.~~

22 ~~(3) The total number of days approved.~~

23 ~~(4) The date of admission or initiation of services, if~~
24 ~~applicable.~~

25 ~~(c) Neither the utilization review entity nor the payer or~~
26 ~~health insurer that has retained the utilization review entity~~
27 ~~may retroactively deny coverage for emergency or nonemergency~~
28 ~~care that had been preauthorized when the care was provided, if~~
29 ~~the information provided was accurate.~~

30 ~~(d) In the event a health care provider obtains~~

~~1 preauthorization for one (1) service but the service provided is
2 not an exact match to the service that was preauthorized, but
3 the service does not materially depart from the service that was
4 preauthorized, a health plan shall not deny payment for the
5 service only if:~~

~~6 (1) the date of service differs by less than thirty (30)
7 days;~~

~~8 (2) the physician or health care provider rendering the
9 service differs from the physician or health care provider that
10 was indicated on the preauthorization, but is otherwise licensed
11 and qualified to provide the preauthorized service; or~~

~~12 (3) the service provided is different than what was
13 preauthorized but is commonly and appropriately a substitute
14 based on common procedural terminology.~~

~~15 (e) If the denial of preauthorization is conditioned upon
16 incomplete information or administrative error, the health plan
17 shall allow the health care provider to resubmit the claim with
18 corrected information for appropriate reimbursement up to thirty
19 (30) days after receiving notice.~~

~~20 (f) (1) If a utilization review entity questions the
21 medical necessity of a health care service, the utilization
22 review entity shall notify the insured's health care provider
23 that medical necessity is being questioned and provide the basis
24 of the challenge in sufficient detail to allow the provider to
25 meaningfully address the concern of the utilization review
26 entity prior to issuing an adverse determination.~~

~~27 (2) The insured's health care provider or the health care
28 provider's designee and the insured or insured's designee shall
29 have the right to discuss the medical necessity of the health
30 care service with the utilization review physician.~~

1 ~~(3) A utilization review entity questioning medical~~
2 ~~necessity of a health care service which may result in an~~
3 ~~adverse determination shall make the reviewing physician or a~~
4 ~~physician who is part of a team making the decision available~~
5 ~~telephonically between the hours of seven (7) o'clock~~
6 ~~antemeridian and seven (7) o'clock postmeridian.~~

7 ~~(g) When making a determination based on medical necessity,~~
8 ~~a utilization review entity shall base the determination on an~~
9 ~~insured's presenting symptoms, diagnosis and information~~
10 ~~available through the course of treatment or at the time of~~
11 ~~admission or presentation at the emergency department.~~

12 ~~(h) In the event a utilization review entity determines an~~
13 ~~alternative level of care is appropriate, the utilization review~~
14 ~~entity shall provide and cite the specific criteria used as the~~
15 ~~basis for the level of care determination to the health care~~
16 ~~provider, prior to denial to enable a meaningful peer to peer~~
17 ~~review. If, after the peer to peer has been completed, denial~~
18 ~~remains the determination, the health care provider shall have~~
19 ~~the right to appeal the determination.~~

20 ~~(i) A utilization review entity may not issue an adverse~~
21 ~~determination for a procedure due to lack of preauthorization if~~
22 ~~the procedure is medically necessary or clinically appropriate~~
23 ~~for the patient's medical condition and rendered at the same~~
24 ~~time as a related procedure for which preauthorization was~~
25 ~~required and received.~~

26 ~~(j) A utilization review entity shall make a~~
27 ~~preauthorization or adverse determination and notify the insured~~
28 ~~and the insured's health care practitioner as follows:~~

29 ~~(1) For nonurgent health care services, within seventy two~~
30 ~~(72) hours of obtaining all the necessary information to make~~

1 ~~the preauthorization or adverse determination.~~

2 ~~(2) For urgent health care services, within twenty four (24)~~
3 ~~hours of obtaining all the necessary information to make the~~
4 ~~preauthorization or adverse determination.~~

5 ~~(k) No utilization review entity may require~~
6 ~~preauthorization for an emergency service, including~~
7 ~~postevaluation and poststabilization services.~~

8 ~~Section 2161.2. Appeals. (a) An insured or the insured's~~
9 ~~health care provider may request an expedited appeal of an~~
10 ~~adverse determination via telephone, facsimile, electronic mail~~
11 ~~or other expeditious method. Within one (1) day of receiving an~~
12 ~~expedited appeal and all information necessary to decide the~~
13 ~~appeal, the utilization review entity shall provide the insured~~
14 ~~and the insured's health care provider written confirmation of~~
15 ~~the expedited review determination.~~

16 ~~(b) An appeal shall be reviewed only by a physician who~~
17 ~~satisfies any of the following conditions:~~

18 ~~(1) Is board certified in the same specialty as a health~~
19 ~~care practitioner who typically manages the medical condition or~~
20 ~~disease.~~

21 ~~(2) Is currently in active practice, provided that in events~~
22 ~~where circumstances justify it or where the provider seeking~~
23 ~~preauthorization specifically requests a health care provider~~
24 ~~actively engaged in the specialty who typically manages the~~
25 ~~medical condition or disease, the physician shall be made~~
26 ~~available for the review.~~

27 ~~(3) Is knowledgeable of, and has experience in, providing~~
28 ~~the health care services under appeal.~~

29 ~~(4) Is under contract with a utilization review entity to~~
30 ~~perform reviews of appeals and payment of fees due under the~~

1 ~~contract, but the performance and payment is not subject to or~~
2 ~~contingent upon the outcome of the appeal.~~

3 ~~The physician may also be subject to a provider agreement~~
4 ~~with the insurer as a provider, but may not receive any other~~
5 ~~fee or compensation from the insurer. The physician's receipt of~~
6 ~~compensation from the utilization review entity shall not be~~
7 ~~considered by the physician in determining the conclusion~~
8 ~~reached by the physician. The physician shall at all times~~
9 ~~render independent and accurate medical judgment in reaching an~~
10 ~~opinion or conclusion. Failure to comply with this provision~~
11 ~~shall render the physician subject to licensure disciplinary~~
12 ~~action by the appropriate State licensing board.~~

13 ~~(5) Not involved in making the adverse determination.~~

14 ~~(6) Familiar with all known clinical aspects of the health~~
15 ~~care services under review, including, but not limited to, all~~
16 ~~pertinent medical records provided to the utilization review~~
17 ~~entity by the insured's health care provider and any relevant~~
18 ~~record provided to the utilization review entity by a health~~
19 ~~care facility.~~

20 ~~(c) The utilization review entity shall ensure that appeal~~
21 ~~procedures satisfy the following requirements:~~

22 ~~(1) The insured and the insured's health care provider may~~
23 ~~challenge the adverse determination and have the right to appear~~
24 ~~in person before the physician who reviews the adverse~~
25 ~~determination.~~

26 ~~(2) The utilization review entity shall provide the insured~~
27 ~~and the insured's health care provider with written notice of~~
28 ~~the time and place concerning where the review meeting will take~~
29 ~~place. Notice shall be given to the insured's health care~~
30 ~~provider at least fifteen (15) days in advance of the review~~

1 ~~meeting.~~

2 ~~(3) If the insured or the insured's health care provider~~
3 ~~appear in person, the utilization review entity shall offer the~~
4 ~~insured or insured's health care provider the opportunity to~~
5 ~~communicate with the reviewing physician, at the utilization~~
6 ~~review entity's expense, by conference call, video conferencing~~
7 ~~or other available technology.~~

8 ~~(4) The physician performing the review of the appeal shall~~
9 ~~consider all information, documentation or other material~~
10 ~~submitted in connection with the appeal without regard to~~
11 ~~whether the information was considered in making the adverse~~
12 ~~determination.~~

13 ~~(d) The following deadlines shall apply to the utilization~~
14 ~~review entities:~~

15 ~~(1) A utilization review entity shall decide an expedited~~
16 ~~appeal and notify the insured and the insured's health care~~
17 ~~provider of the determination within three (3) days after~~
18 ~~receiving a notice of expedited appeal by the insured or the~~
19 ~~insured's health care provider and all information necessary to~~
20 ~~decide the appeal.~~

21 ~~(2) A utilization review entity shall issue a written~~
22 ~~determination concerning a nonexpedited appeal not later than~~
23 ~~thirty (30) days after receiving a notice of appeal from an~~
24 ~~insured or insured's health care provider and all information~~
25 ~~necessary to decide the appeal.~~

26 ~~(e) Written notice of final adverse determinations shall be~~
27 ~~provided to the insured and the insured's health care provider.~~

28 ~~(f) If the insured or the insured's health care provider or~~
29 ~~a designee on behalf of either the insured or the insured's~~
30 ~~health care provider has satisfied all necessary requirements~~

~~1 for the appeal of an adverse determination through the
2 preauthorization process and the appeal has resulted in a
3 continued adverse determination either based on lack of medical
4 necessity or an administrative defect, the insured, the
5 insured's health care provider or a designee on behalf of either
6 the insured or the insured's health care provider or a designee
7 may file a consumer complaint with the Insurance Department. The
8 complaint shall be adjudicated without unnecessary delay and a
9 determination issued by the Insurance Department with
10 appropriate sanctions, if applicable, pursuant to the authority
11 given to the Insurance Department.~~

~~12 (g) To the extent that an insured, an insured's health care
13 provider or a designee on behalf of either the insured or the
14 insured's health care provider or a designee files a consumer
15 complaint with the department or the Office of Attorney General
16 pursuant to their authority to receive such complaints, a copy
17 of the complaint filed with either the department or the Office
18 of Attorney General shall be forwarded to the Insurance
19 Department and the copy shall serve as a new consumer complaint
20 to be adjudicated pursuant to the terms of this section and all
21 other applicable law.~~

~~22 (h) Nothing in this section shall be construed to preclude
23 an insured or an insured's designee the ability to file a
24 separate consumer complaint with the Insurance Department for
25 failure to comply with the requirements of this act as it
26 applies to preauthorization processes or denial of health
27 insurance coverage generally.~~

~~28 Section 2195. Access Requirements in Service Areas. If a
29 patient's safe discharge is delayed for any reason, including
30 lack of available posthospitalization services, including, but~~

1 ~~not limited to, skilled nursing facilities, home health services~~
2 ~~and postacute rehabilitation, the managed care plan shall~~
3 ~~reimburse the hospital for each subsequent date of service at~~
4 ~~the greater of the contracted rate with the managed care plan~~
5 ~~for the current level of care and service or the full diagnostic~~
6 ~~related group payment divided by the mean length of stay for the~~
7 ~~particular diagnostic related group.~~

8 ~~Section 2196. Uniform Preauthorization Form. (a) Within~~
9 ~~three (3) months of the effective date of this section, the~~
10 ~~Insurance Department shall convene a panel to develop a uniform~~
11 ~~preauthorization form that all health care providers in this~~
12 ~~Commonwealth shall use to request preauthorization and that all~~
13 ~~health insurers shall accept as sufficient to request~~
14 ~~preauthorization of health care services.~~

15 ~~(b) The panel shall consist of not fewer than ten (10)~~
16 ~~persons. Equal representation shall be afforded to the~~
17 ~~physician, health care facility, employer, health insurer and~~
18 ~~consumer protection communities within this Commonwealth.~~

19 ~~(c) Within one (1) year of the effective date of this~~
20 ~~section, the panel shall conclude development of the uniform~~
21 ~~preauthorization form and the Insurance Department shall make~~
22 ~~the uniform preauthorization form available to health care~~
23 ~~providers in this Commonwealth and utilization review entities~~
24 ~~and agents.~~

25 ~~Section 2197. Preauthorization Exemptions. A health care~~
26 ~~service that has been provided following approval through the~~
27 ~~preauthorization procedures provided by the insurer or which~~
28 ~~have been disclosed as not subject to preauthorization~~
29 ~~procedures shall not be subject to retrospective review or~~
30 ~~concurrent review based on medical necessity related to the~~

1 ~~preauthorization.~~

2 ~~Section 2198. Data Collection and Reporting. (a) The~~
3 ~~Insurance Department shall maintain and collect data on the~~
4 ~~number of appeals filed by enrollees, enrollee designees and~~
5 ~~health care providers with utilization review entities.~~

6 ~~(b) The Insurance Department shall, on an annual basis,~~
7 ~~publish a report made accessible on the department's publicly~~
8 ~~accessible Internet website and serve a copy of the report on~~
9 ~~the Banking and Insurance Committee of the Senate and the~~
10 ~~Insurance Committee of the House of Representatives that~~
11 ~~identifies the following data elements by place and type of~~
12 ~~service:~~

13 ~~(1) The total number of appeals filed against utilization~~
14 ~~review entities.~~

15 ~~(2) The number and percentage of appeals filed against each~~
16 ~~utilization review entity.~~

17 ~~(3) The total number of appeals found in favor of~~
18 ~~utilization review entities.~~

19 ~~(4) The number and percentage of appeals found in favor of~~
20 ~~each managed care plan.~~

21 ~~(5) The total number of appeals found in favor of the~~
22 ~~enrollee, designee or health care provider.~~

23 ~~(6) The number and percentage of appeals found in favor of~~
24 ~~the enrollee, designee or health care provider against each~~
25 ~~managed care plan.~~

26 ~~(c) The Insurance Department shall evaluate, monitor and~~
27 ~~track health plan statistics per the information gathered in~~
28 ~~subsection (a) and investigate negative trends and outliers and~~
29 ~~shall facilitate meetings between health care providers and~~
30 ~~managed care plans to discuss and resolve disputes.~~

1 MANAGED CARE PLAN THAT HAS BEEN DENIED, MODIFIED OR TERMINATED
2 EITHER PRIOR TO THE REQUEST FOR PREAUTHORIZATION OR AS A RESULT
3 OF THE REQUESTED PREAUTHORIZATION.

4 (2) THE TERM INCLUDES A DECISION TO DENY A STEP THERAPY
5 EXCEPTION REQUEST UNDER SECTION 2118.

6 (3) THE TERM DOES NOT INCLUDE A DECISION TO DENY, REDUCE OR
7 TERMINATE SERVICES THAT ARE NOT COVERED FOR REASONS OTHER THAN
8 MEDICAL NECESSITY, EXPERIMENTAL OR INVESTIGATIONAL NATURE.

9 * * *

10 "AUTHORIZATION." A DETERMINATION BY A MANAGED CARE PLAN OR
11 UTILIZATION REVIEW ENTITY THAT:

12 (1) A HEALTH CARE SERVICE HAS BEEN REVIEWED AND, BASED ON
13 THE INFORMATION PROVIDED, IS MEDICALLY NECESSARY.

14 (2) THE HEALTH CARE SERVICE REVIEWED IS A COVERED SERVICE
15 UNDER THE PLAN.

16 (3) PAYMENT WILL BE MADE FOR THE HEALTH CARE SERVICE SUBJECT
17 TO COPAY, DEDUCTIBLE AND HEALTH CARE NETWORK RESTRICTIONS.

18 * * *

19 "CLINICAL CRITERIA." POLICIES, SCREENING PROCEDURES,
20 DETERMINATION RULES, DETERMINATION ABSTRACTS, CLINICAL
21 PROTOCOLS, PRACTICE GUIDELINES AND MEDICAL PROTOCOLS THAT ARE
22 SPECIFIED IN A WRITTEN DOCUMENT AVAILABLE FOR PEER-TO-PEER
23 REVIEW BY A PEER WITHIN THE SAME PROFESSION AND SPECIALTY AND
24 SUBJECT TO CHALLENGE BY AN ENROLLEE, A PROVIDER OR A PROVIDER
25 ORGANIZATION WHEN USED AS A BASIS TO WITHHOLD PREAUTHORIZATION,
26 DENY OR OTHERWISE MODIFY COVERAGE AND THAT IS USED BY A
27 UTILIZATION REVIEW ENTITY TO DETERMINE THE MEDICAL NECESSITY OF
28 HEALTH CARE SERVICES. THE CRITERIA SHALL:

29 (1) BE BASED ON NATIONALLY RECOGNIZED STANDARDS.

30 (2) BE DEVELOPED IN ACCORDANCE WITH THE CURRENT STANDARDS OF

1 NATIONAL ACCREDITATION ENTITIES.

2 (3) REFLECT COMMUNITY STANDARDS OF CARE.

3 (4) ENSURE QUALITY OF CARE AND ACCESS TO NEEDED HEALTH CARE
4 SERVICES.

5 (5) BE EVIDENCE-BASED OR BASED ON GENERALLY ACCEPTED EXPERT
6 CONSENSUS STANDARDS.

7 (6) BE SUFFICIENTLY FLEXIBLE TO ALLOW DEVIATIONS FROM THE
8 STANDARDS WHEN JUSTIFIED ON A CASE-BY-CASE BASIS.

9 (7) BE EVALUATED AND UPDATED ANNUALLY.

10 * * *

11 "EMERGENCY SERVICE." ANY HEALTH CARE SERVICE PROVIDED TO AN
12 ENROLLEE, INCLUDING PREHOSPITAL TRANSPORTATION OR TREATMENT BY
13 EMERGENCY MEDICAL SERVICES PROVIDERS, AFTER THE SUDDEN ONSET OF
14 A MEDICAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF
15 SUFFICIENT SEVERITY OR SEVERE PAIN SUCH THAT A PRUDENT LAYPERSON
16 WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD
17 REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO
18 RESULT IN:

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

22 (2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

23 (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

24 EMERGENCY TRANSPORTATION AND RELATED EMERGENCY SERVICE PROVIDED
25 BY A LICENSED AMBULANCE SERVICE SHALL CONSTITUTE AN EMERGENCY
26 SERVICE.

27 * * *

28 "FINAL ADVERSE DETERMINATION." AN ADVERSE DETERMINATION THAT
29 HAS BEEN UPHELD BY A UTILIZATION REVIEW ENTITY OR MANAGED CARE
30 PLAN AT THE COMPLETION OF THE INTERNAL GRIEVANCE PROCESS.

1 "GRIEVANCE." AS PROVIDED IN SUBDIVISION (I), A REQUEST BY AN
2 ENROLLEE OR A HEALTH CARE PROVIDER, WITH THE WRITTEN CONSENT OF
3 THE ENROLLEE, TO HAVE A MANAGED CARE PLAN OR UTILIZATION REVIEW
4 ENTITY RECONSIDER A DECISION SOLELY CONCERNING THE MEDICAL
5 NECESSITY [AND APPROPRIATENESS] OF A HEALTH CARE SERVICE. IF THE
6 MANAGED CARE PLAN IS UNABLE TO RESOLVE THE MATTER, A GRIEVANCE
7 MAY BE FILED REGARDING THE DECISION THAT:

8 (1) DISAPPROVES FULL OR PARTIAL PAYMENT FOR A REQUESTED
9 HEALTH CARE SERVICE;

10 (2) APPROVES THE PROVISION OF A REQUESTED HEALTH CARE
11 SERVICE FOR A LESSER SCOPE OR DURATION THAN REQUESTED; OR

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

15 THE TERM DOES NOT INCLUDE A COMPLAINT.

16 * * *

17 "HEALTH CARE SERVICE." ANY [COVERED] TREATMENT, ADMISSION,
18 PROCEDURE, TEST USED TO AID IN DIAGNOSIS OR THE PROVISIONS OF
19 THE APPLICABLE TREATMENT, PHARMACEUTICAL PRODUCT, MEDICAL
20 SUPPLIES AND EQUIPMENT OR OTHER SERVICES, INCLUDING BEHAVIORAL
21 HEALTH[, PRESCRIBED OR OTHERWISE] PROVIDED OR PROPOSED TO BE
22 PROVIDED BY A HEALTH CARE PROVIDER TO AN ENROLLEE UNDER A
23 MANAGED CARE PLAN CONTRACT.

24 * * *

25 "MEDICALLY NECESSARY HEALTH CARE SERVICES" OR "MEDICALLY
26 NECESSARY." HEALTH CARE SERVICES THAT A PRUDENT HEALTH CARE
27 PROVIDER WOULD PROVIDE TO A PATIENT FOR THE PURPOSE OF
28 PREVENTING, DIAGNOSING OR TREATING AN ILLNESS, INJURY, DISEASE
29 OR ITS SYMPTOMS IN A MANNER THAT MEETS ALL THE FOLLOWING:

30 (1) IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF

1 MEDICAL PRACTICE BASED ON CLINICAL CRITERIA.

2 (2) APPROPRIATE IN TERMS OF TYPE, FREQUENCY, EXTENT, SITE
3 AND DURATION IN ACCORDANCE WITH CLINICAL CRITERIA.

4 "NONURGENT HEALTH CARE SERVICE." A HEALTH CARE SERVICE
5 PROVIDED TO AN ENROLLEE THAT IS NOT CONSIDERED AN EMERGENCY
6 SERVICE OR AN URGENT HEALTH CARE SERVICE.

7 * * *

8 "PROSPECTIVE UTILIZATION REVIEW[.]," "PREAUTHORIZATION" OR
9 "PRIOR AUTHORIZATION." A REVIEW BY A UTILIZATION REVIEW ENTITY
10 OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION THAT OCCURS
11 PRIOR TO THE DELIVERY OR PROVISION OF A HEALTH CARE SERVICE AND
12 RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH
13 CARE SERVICE.

14 * * *

15 "RETROSPECTIVE UTILIZATION REVIEW[.]" OR "RETROSPECTIVE
16 REVIEW." A REVIEW BY A UTILIZATION REVIEW ENTITY OF ALL
17 REASONABLY NECESSARY SUPPORTING INFORMATION WHICH OCCURS
18 FOLLOWING DELIVERY OR PROVISION OF A HEALTH CARE SERVICE AND
19 RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH
20 CARE SERVICE.

21 * * *

22 "URGENT HEALTH CARE SERVICE." THE FOLLOWING SHALL APPLY:

23 (1) A HEALTH CARE SERVICE DEEMED BY A PROVIDER TO REQUIRE
24 EXPEDITED PREAUTHORIZATION REVIEW IN THE EVENT A DELAY MAY
25 JEOPARDIZE LIFE OR HEALTH OF THE ENROLLEE OR A DELAY IN
26 TREATMENT COULD DO ANY OF THE FOLLOWING:

27 (I) NEGATIVELY AFFECT THE ABILITY OF THE ENROLLEE TO REGAIN
28 MAXIMUM FUNCTION.

29 (II) SUBJECT THE ENROLLEE TO SEVERE PAIN THAT CANNOT BE
30 ADEQUATELY MANAGED WITHOUT RECEIVING THE CARE OR TREATMENT THAT

1 IS THE SUBJECT OF THE UTILIZATION REVIEW AS QUICKLY AS POSSIBLE.

2 (2) THE TERM DOES NOT INCLUDE AN EMERGENCY SERVICE OR
3 NONURGENT HEALTH CARE SERVICE.

4 "UTILIZATION REVIEW." A SYSTEM OF PROSPECTIVE, CONCURRENT OR
5 RETROSPECTIVE UTILIZATION REVIEW PERFORMED BY A UTILIZATION
6 REVIEW ENTITY OF THE MEDICAL NECESSITY [AND APPROPRIATENESS] OF
7 HEALTH CARE SERVICES PRESCRIBED, PROVIDED OR PROPOSED TO BE
8 PROVIDED TO AN ENROLLEE. THE TERM DOES NOT INCLUDE ANY OF THE
9 FOLLOWING:

10 (1) REQUESTS FOR CLARIFICATION OF COVERAGE, ELIGIBILITY OR
11 HEALTH CARE SERVICE VERIFICATION.

12 (2) A HEALTH CARE PROVIDER'S INTERNAL QUALITY ASSURANCE OR
13 UTILIZATION REVIEW PROCESS UNLESS THE REVIEW RESULTS IN DENIAL
14 OF PAYMENT FOR A HEALTH CARE SERVICE.

15 "UTILIZATION REVIEW ENTITY." ANY ENTITY CERTIFIED PURSUANT
16 TO SUBDIVISION (H) THAT PERFORMS UTILIZATION REVIEW ON BEHALF OF
17 A MANAGED CARE PLAN. THE TERM INCLUDES ALL THE FOLLOWING:

18 (1) AN INSURER THAT WRITES HEALTH INSURANCE POLICIES,
19 INCLUDING PREFERRED PROVIDER ORGANIZATIONS AS DEFINED IN SECTION
20 630.

21 (2) PHARMACY BENEFITS MANAGERS RESPONSIBLE FOR MANAGING
22 ACCESS OF ENROLLEES TO AVAILABLE PHARMACEUTICAL OR
23 PHARMACOLOGICAL CARE.

24 (3) A HEALTH INSURER IF THE HEALTH INSURERE PERFORMS
25 UTILIZATION REVIEW.

26 SECTION 2. SECTION 2111(3) OF THE ACT IS AMENDED AND THE
27 SECTION IS AMENDED BY ADDING PARAGRAPHS TO READ:

28 SECTION 2111. RESPONSIBILITIES OF MANAGED CARE PLANS.--A
29 MANAGED CARE PLAN SHALL DO ALL OF THE FOLLOWING:

30 * * *

1 (3) [ADOPT AND MAINTAIN A DEFINITION OF MEDICAL NECESSITY
2 USED BY THE PLAN IN DETERMINING HEALTH CARE SERVICES.]

3 ESTABLISH AN ELECTRONIC PLATFORM AND PROCESS FOR THE SUBMISSION
4 AND RECEIPT OF PRIOR AUTHORIZATION REQUESTS BY NETWORK
5 PROVIDERS. THE FOLLOWING SHALL APPLY:

6 (I) EACH MANAGED CARE PLAN MUST PROVIDE WRITTEN INSTRUCTIONS
7 AND TRAINING TO NETWORK PROVIDERS WHO MAY SUBMIT REQUESTS USING
8 THE ELECTRONIC PLATFORM THAT SET FORTH PROTOCOLS ADDRESSING
9 SUBMISSION OF PREAUTHORIZATION REQUESTS IF ANY OF THE FOLLOWING
10 APPLY:

11 (A) THE ELECTRONIC PLATFORM IS NOT AVAILABLE DUE TO
12 TECHNOLOGICAL FAILURE OR ELECTRONIC FAILURE.

13 (B) DOCUMENTS REQUESTED BY THE MANAGED CARE PLAN OR
14 UTILIZATION REVIEW ENTITY EXCEED THE SUBMISSION CAPACITY
15 LIMITATIONS OF THE ELECTRONIC PLATFORM.

16 (II) EACH MANAGED HEALTH CARE PLAN SHALL ESTABLISH MUTUALLY
17 AGREEABLE TERMS FOR SUBMISSION OF PREAUTHORIZATION REQUESTS AND
18 COMMUNICATION REGARDING PREAUTHORIZATION IN CIRCUMSTANCES WHERE
19 A NETWORK PROVIDER OR HEALTH CARE FACILITY DOES NOT HAVE EITHER
20 OF THE FOLLOWING:

21 (A) INTERNET ACCESS.

22 (B) AN ELECTRONIC HEALTH RECORD SYSTEMS.

23 * * *

24 (14) PUBLISH AVAILABLE HEALTH CARE SERVICES SUBJECT TO PRIOR
25 AUTHORIZATION ON ITS PUBLICLY ACCESSIBLE INTERNET WEBSITE IN AN
26 EASILY ACCESSIBLE MANNER AND SHALL PROVIDE THE INFORMATION UPON
27 REQUEST OF A PARTICIPATING NETWORK PROVIDER.

28 (15) PROVIDE SIXTY (60) DAYS NOTICE TO PARTICIPATING NETWORK
29 PROVIDERS OF ANY CHANGES TO EXISTING PRIOR AUTHORIZATION
30 CRITERIA OR IMPLEMENTATION OF NEW PRIOR AUTHORIZATION

1 REQUIREMENTS.

2 (16) ESTABLISH A PROTOCOL TO OBTAIN AN EXCEPTION FROM ANY
3 STEP THERAPY REQUIREMENTS AND PUBLISH THAT PROCESS IN AN EASILY
4 ACCESSIBLE MANNER ON ITS PUBLICLY ACCESSIBLE INTERNET WEBSITE.

5 (17) PROVIDE THE RULES AND CRITERIA RELATED TO THE STEP
6 THERAPY PROTOCOL UPON REQUEST TO ALL PRESCRIBING NETWORK
7 PROVIDERS.

8 SECTION 3. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

9 SECTION 2114. PREAUTHORIZATION REVIEW STANDARDS.--(A)
10 PREAUTHORIZATION APPROVAL REQUESTS MAY BE SUBMITTED
11 ELECTRONICALLY THROUGH A SECURE ELECTRONIC TRANSMISSION PLATFORM
12 ESTABLISHED AND MAINTAINED BY A MANAGED CARE PLAN UNDER SECTION
13 2111(3). AN ELECTRONIC SUBMISSION SHALL NOT BE REQUIRED IN
14 CIRCUMSTANCES WHERE THE MANAGED CARE PLAN HAS NOT PUBLISHED
15 PROTOCOLS OR PROVIDED TRAINING AS REQUIRED BY SECTION 2111(3).

16 (B) ANY RESTRICTION THAT A UTILIZATION REVIEW ENTITY PLACES
17 ON THE PREAUTHORIZATION OF HEALTH CARE SERVICES SHALL BE IN
18 ACCORDANCE WITH THE FOLLOWING:

19 (1) BASED ON THE MEDICAL NECESSITY OF THOSE SERVICES AND ON
20 ANY ADDITIONAL CLINICAL CRITERIA INFORMATION SUBMITTED BY THE
21 PROVIDER SEEKING AUTHORIZATION OF THE HEALTH CARE SERVICE ON
22 BEHALF OF THE ENROLLEE.

23 (2) APPLIED CONSISTENTLY.

24 (3) DISCLOSED BY THE MANAGED CARE PLAN OR UTILIZATION REVIEW
25 ENTITY UNDER SECTIONS 2111 AND 2136.

26 (C) ADVERSE DETERMINATIONS AND FINAL ADVERSE DETERMINATIONS
27 MADE BY A UTILIZATION REVIEW ENTITY OR AGENT THEREOF SHALL BE
28 BASED ON MEDICAL NECESSITY AND SUPPORTING CLINICAL CRITERIA
29 SUBMITTED BY THE PROVIDER SEEKING AUTHORIZATION FOR THE HEALTH
30 CARE SERVICE ON BEHALF OF THE ENROLLEE.

1 (D) A UTILIZATION REVIEW ENTITY SHALL NOT DENY COVERAGE OF A
2 HEALTH CARE SERVICE SOLELY BASED ON THE GROUNDS THAT THE HEALTH
3 CARE SERVICE DOES NOT MEET CLINICAL CRITERIA.

4 (E) PREAUTHORIZATION SHALL NOT BE REQUIRED IN ANY OF THE
5 FOLLOWING:

6 (1) IF A PRESCRIBED MEDICATION IS A NONCONTROLLED GENERIC
7 MEDICATION.

8 (2) IF A PROCEDURE TO BE PERFORMED IS CUSTOMARY AND PROPERLY
9 INDICATED OR IS A TREATMENT FOR THE CLINICAL INDICATION AS
10 SUPPORTED BY PEER-REVIEWED MEDICAL PUBLICATIONS.

11 (3) FOR THE PROVISION OF MAT FOR THE TREATMENT OF AN OPIOID-
12 USE DISORDER.

13 (F) IF A PROVIDER CONTACTS A UTILIZATION REVIEW ENTITY
14 SEEKING PREAUTHORIZATION FOR A MEDICALLY NECESSARY HEALTH CARE
15 SERVICE UNDER SECTION 2111(14) AND THE UTILIZATION REVIEW
16 ENTITY, THROUGH AN AGENT, CONTRACTOR, EMPLOYE OR REPRESENTATIVE
17 INFORMS THE PROVIDER THAT PREAUTHORIZATION IS NOT REQUIRED FOR
18 THE HEALTH CARE SERVICE SUBJECT TO THE REQUEST, COVERAGE FOR THE
19 SERVICE SHALL BE DEEMED APPROVED.

20 SECTION 2115. PREAUTHORIZATION COSTS.--(A) IN THE EVENT
21 THAT AN INSURED IS COVERED BY MORE THAN ONE HEALTH PLAN THAT
22 REQUIRES PREAUTHORIZATION:

23 (1) A SECONDARY MANAGED HEALTH CARE PLAN SHALL NOT DENY
24 PREAUTHORIZATION FOR A HEALTH CARE SERVICE SOLELY ON THE BASIS
25 THAT THE PREAUTHORIZATION PROCEDURES OF THE SECONDARY INSURER
26 WERE NOT FOLLOWED IF THE ENROLLEE SUBJECT TO THE PLAN RECEIVED
27 PREAUTHORIZATION FROM THE ENROLLEE'S PRIMARY MANAGED HEALTH CARE
28 PLAN.

29 (2) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PRECLUDE A
30 SECONDARY INSURER FROM REQUIRING PREAUTHORIZATION FOR A HEALTH

1 CARE SERVICE DENIED PREAUTHORIZATION BY A PRIMARY INSURER.

2 (B) ANY INTERNAL GRIEVANCE OR INTERNAL REVIEW OF AN ADVERSE
3 DETERMINATION OF A FINAL ADVERSE DETERMINATION SHALL BE PROVIDED
4 WITHOUT CHARGE TO THE ENROLLEE OR ENROLLEE'S HEALTH CARE
5 PROVIDER.

6 SECTION 4. SECTION 2117 OF THE ACT IS AMENDED BY ADDING
7 SUBSECTIONS TO READ:

8 SECTION 2117. CONTINUITY OF CARE.--* * *

9 (G) IF THE APPEAL OF AN ADVERSE DETERMINATION FROM A
10 PREAUTHORIZATION REQUEST CONCERNS ONGOING HEALTH CARE SERVICES
11 PROVIDED UNDER AN INITIALLY AUTHORIZED ADMISSION OR COURSE OF
12 TREATMENT, THE HEALTH CARE SERVICES SHALL CONTINUE TO BE
13 PROVIDED TO THE ENROLLEE AND PAID FOR BY THE MANAGED CARE PLAN
14 WITHOUT LIABILITY TO THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE
15 PROVIDER FOR NO LESS THAN SIXTY (60) DAYS.

16 (H) THE MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY SHALL
17 NOT BE PERMITTED TO RETROACTIVELY REVIEW THE DECISION TO
18 AUTHORIZE AND PROVIDE HEALTH CARE SERVICES THROUGH
19 PREAUTHORIZATION, INCLUDING PREAUTHORIZATION FOR EXTENDING THE
20 TERM OR COURSE OF TREATMENT UNLESS THE MANAGED CARE PLAN OR
21 UTILIZATION REVIEW ENTITY CAN DEMONSTRATE BY CLEAR AND
22 CONVINCING EVIDENCE THAT PREAUTHORIZATION WAS AUTHORIZED USING
23 KNOWINGLY INACCURATE CLINICAL INFORMATION SUBMITTED BY THE
24 PROVIDER OR FRAUD.

25 (I) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, THE MANAGED
26 CARE PLAN SHALL NOT RETROACTIVELY RECOVER THE COST OF TREATMENT
27 EITHER FOR THE INITIAL PERIOD OF TREATMENT SUBJECT TO
28 PREAUTHORIZATION OR THE PERIOD OF TREATMENT PROVIDED TO THE
29 ENROLLEE AS PART OF THE PREAUTHORIZATION DECISION-MAKING PROCESS
30 TO AUTHORIZE COVERAGE OF ADDITIONAL TREATMENT PERIODS.

1 (J) CONTINUED CARE SHALL NOT BE SUBJECT TO CONCURRENT REVIEW
2 IF THE TREATMENT REGIMEN OR CONTINUITY OF CARE FOLLOWS FROM A
3 AUTHORIZING PREVIOUS PREAUTHORIZATION REQUEST UNLESS THE MANAGED
4 CARE PLAN OR UTILIZATION REVIEW ENTITY CAN DEMONSTRATE BY CLEAR
5 AND CONVINCING EVIDENCE THAT PREAUTHORIZATION WAS AUTHORIZED
6 USING KNOWINGLY INACCURATE CLINICAL INFORMATION SUBMITTED BY THE
7 PROVIDER OR FRAUD.

8 SECTION 5. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

9 SECTION 2118. STEP THERAPY.--(A) (1) WHEN COVERAGE OF A
10 PRESCRIPTION DRUG FOR THE TREATMENT OF ANY MEDICAL CONDITION IS
11 RESTRICTED FOR USE BY A MANAGED CARE PLAN OR UTILIZATION REVIEW
12 ENTITY THROUGH A STEP THERAPY PROTOCOL, THE ENROLLEE AND
13 PROVIDER SHALL HAVE ACCESS TO A CLEAR, READILY ACCESSIBLE AND
14 CONVENIENT PROCESS TO REQUEST A STEP THERAPY EXCEPTION UNDER
15 SECTION 2111(16). FAILURE OF THE MANAGED CARE PLAN TO MEET ITS
16 OBLIGATION UNDER SECTION 2111 SHALL RESULT IN ALL STEP THERAPY
17 EXCEPTIONS BEING DEEMED APPROVED UNTIL THE MANAGED CARE PLAN
18 COMPLIES WITH THE REQUIREMENTS OF SECTION 2111(16).

19 (2) NO STEP THERAPY SHALL BE REQUIRED IF THE MEDICATION
20 BEING PRESCRIBED IS BEING PRESCRIBED IN RESPONSE TO AN
21 EMERGENCY.

22 (3) A STEP THERAPY EXCEPTION SHALL BE GRANTED IF ANY OF THE
23 FOLLOWING APPLY:

24 (I) THE REQUIRED PRESCRIPTION DRUG IS CONTRAINDICATED, NOT
25 IN THE BEST INTEREST OF THE ENROLLEE OR WILL LIKELY CAUSE AN
26 ADVERSE REACTION BY OR PHYSICAL OR MENTAL HARM TO THE ENROLLEE.

27 (II) THE REQUIRED PRESCRIPTION DRUG IS EXPECTED TO BE
28 INEFFECTIVE BASED ON THE KNOWN CLINICAL CHARACTERISTICS OF THE
29 ENROLLEE AND THE KNOWN CHARACTERISTICS OF THE PRESCRIPTION DRUG
30 REGIMEN.

1 (III) THE ENROLLEE HAS TRIED THE REQUIRED PRESCRIPTION DRUG
2 WHILE UNDER THE ENROLLEE'S CURRENT OR PREVIOUS HEALTH CARE PLAN
3 OR HEALTH BENEFIT PLAN, OR ANOTHER PRESCRIPTION DRUG IN THE SAME
4 PHARMACOLOGIC CLASS OR WITH THE SAME MECHANISM OF ACTION, AND
5 THE PRESCRIPTION DRUG WAS DISCONTINUED DUE TO LACK OF EFFICACY
6 OR EFFECTIVENESS, DIMINISHED EFFECT OR AN ADVERSE EVENT.

7 (IV) THE ENROLLEE IS STABLE ON A PRESCRIPTION DRUG
8 PREVIOUSLY SELECTED BY THE ENROLLEE'S PROVIDER AND PREVIOUSLY
9 APPROVED BY A MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY.

10 (4) GRANTING THE STEP THERAPY EXCEPTION SHALL AUTHORIZE
11 COVERAGE FOR THE PRESCRIPTION DRUG PRESCRIBED BY THE ENROLLEE'S
12 TREATING HEALTH CARE PROVIDER.

13 (B) STEP THERAPY EXCEPTION REQUESTS OR AN APPEAL THEREOF
14 SHALL BE GRANTED OR DENIED WITHIN FIVE (5) BUSINESS DAYS OF
15 RECEIPT, SUBJECT TO THE FOLLOWING:

16 (1) IN CASES WHERE THE REQUESTED EXCEPTION IS RELATED TO AN
17 URGENT HEALTHCARE TREATMENT, THE MANAGED CARE PLAN OR
18 UTILIZATION REVIEW ENTITY EVALUATING THE EXCEPTION SHALL RESPOND
19 WITHIN TWENTY-FOUR (24) HOURS OF RECEIPT OF THE REQUEST.

20 (2) IF A REQUEST FOR AN EXCEPTION UNDER THIS SECTION IS
21 INCOMPLETE OR ADDITIONAL CLINICALLY RELEVANT INFORMATION IS
22 REQUIRED, THE MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY
23 SHALL NOTIFY THE PRESCRIBING PRACTITIONER WITHIN FIVE (5)
24 BUSINESS DAYS OF SUBMISSION, OR TWENTY-FOUR (24) HOURS IN AN
25 URGENT HEALTH CARE REQUEST, THAT ADDITIONAL OR CLINICALLY
26 RELEVANT INFORMATION IS REQUIRED IN ORDER TO APPROVE OR DENY THE
27 STEP THERAPY EXCEPTION REQUEST OR APPEAL UNDER THIS SECTION. THE
28 REQUEST FOR ADDITIONAL INFORMATION MAY ONLY EXTEND THE DEADLINES
29 HEREIN AN ADDITIONAL FORTY-EIGHT (48) HOURS FOR NONURGENT
30 HEALTHCARE SERVICES SUBJECT TO STEP THERAPY.

1 (C) IF A DETERMINATION IS NOT RENDERED WITHIN THE APPLICABLE
2 DEADLINES, THE REQUESTED EXCEPTION SHALL BE DEEMED APPROVED, AND
3 TREATMENT AUTHORIZED. IN A CIRCUMSTANCE WHERE THE EXCEPTION HAS
4 BEEN DEEMED APPROVED AND TREATMENT HAS BEEN AUTHORIZED SHALL NOT
5 BE SUBJECT TO CONCURRENT REVIEW OR RETROACTIVE REVIEW BECAUSE OF
6 THE FAILURE OF THE MANAGED CARE PLAN TO RENDER A DETERMINATION
7 UNDER THIS SECTION.

8 (D) IN THE EVENT OF A DENIAL, THE MANAGED CARE PLAN OR
9 UTILIZATION REVIEW ENTITY SHALL INFORM THE ENROLLEE OF THE RIGHT
10 TO A GRIEVANCE PROCESS. THIS SUBSECTION SHALL NOT BE CONSTRUED
11 TO PREVENT:

12 (1) A MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY FROM
13 REQUIRING A PHARMACIST TO EFFECT SUBSTITUTIONS OF PRESCRIPTION
14 DRUGS CONSISTENT WITH THE LAWS OF THIS COMMONWEALTH.

15 (2) A HEALTH CARE PROVIDER FROM PRESCRIBING A PRESCRIPTION
16 DRUG THAT IS DETERMINED TO BE MEDICALLY APPROPRIATE.

17 (E) AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES
18 SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION:

19 "STEP THERAPY EXCEPTION." WHEN A STEP THERAPY PROTOCOL
20 SHOULD BE OVERRIDDEN IN FAVOR OF IMMEDIATE COVERAGE OF THE
21 HEALTH CARE PROVIDER'S SELECTED PRESCRIPTION DRUG.

22 "STEP THERAPY PROTOCOL." A PROTOCOL, POLICY OR PROGRAM THAT
23 ESTABLISHES THE SPECIFIC SEQUENCE IN WHICH PRESCRIPTION DRUGS
24 FOR A SPECIFIED MEDICAL CONDITION AND MEDICALLY APPROPRIATE FOR
25 A PARTICULAR PATIENT ARE COVERED BY AN INSURER OR HEALTH PLAN.

26 SECTION 6. ARTICLE XXI, SUBDIVISION (F) HEADING OF THE ACT
27 IS AMENDED TO READ:

28 (F) INFORMATION FOR ENROLLEES AND HEALTH CARE PROVIDERS.

29 SECTION 7. SECTION 2136 OF THE ACT IS AMENDED BY ADDING A
30 SUBSECTION TO READ:

1 SECTION 2136. REQUIRED DISCLOSURE.--* * *

2 (C) IF EITHER A MANAGED CARE PLAN OR UTILIZATION REVIEW
3 ENTITY INTENDS TO IMPLEMENT A NEW PREAUTHORIZATION REQUIREMENT
4 OR RESTRICTION OR AMEND AN EXISTING REQUIREMENT OR RESTRICTION,
5 THE MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY SHALL PROVIDE
6 NETWORK PROVIDERS AND ENROLLEES WITH WRITTEN NOTICE OF THE NEW
7 OR AMENDED REQUIREMENT OR AMENDMENT NOT LESS THAN SIXTY (60)
8 DAYS BEFORE IMPLEMENTATION. THE NOTICE SHALL BE IN WRITING WHICH
9 MAY BE SATISFIED BY ANY OF THE FOLLOWING:

10 (1) MAIL THROUGH THE UNITED STATES POSTAL SERVICE.

11 (2) ELECTRONIC MAIL READ RECEIPT REQUESTED.

12 (3) PUBLICATION ON THE PUBLICLY ACCESSIBLE INTERNET WEBSITE
13 OF THE MANAGED CARE PLAN OR UTILIZATION REVIEW ENTITY WITH AN
14 ELECTRONIC MAIL MESSAGE TO NETWORK PROVIDERS AND ENROLLEES THAT
15 IDENTIFIES THE LOCATION OF THE PUBLICATION ON THE WEBSITE.

16 (4) WEB-EXCHANGE, PROVIDED THAT AN ELECTRONIC MAIL MESSAGE
17 ON HOW TO ACCESS THE WEB-EXCHANGE IS SENT TO NETWORK PROVIDERS
18 AND ENROLLEES.

19 (5) ANY OTHER CONTRACTUALLY AGREED UPON METHOD, SPECIFYING
20 THE DETAILS OF THE COMMUNICATION WHICH INCLUDE SOME PROOF OF
21 RECEIPT BY THE NETWORK PROVIDERS AND ENROLLEES.

22 SECTION 8. SECTION 2152(A)(4) AND (6) OF THE ACT ARE
23 AMENDED, SUBSECTION (A) IS AMENDED BY ADDING PARAGRAPHS AND THE
24 SECTION IS AMENDED BY ADDING A SUBSECTION TO READ:

25 SECTION 2152. OPERATIONAL STANDARDS.--(A) A UTILIZATION
26 REVIEW ENTITY SHALL DO ALL OF THE FOLLOWING:

27 * * *

28 (4) CONDUCT UTILIZATION REVIEWS BASED ON THE MEDICAL
29 NECESSITY [AND APPROPRIATENESS] OF THE HEALTH CARE SERVICE BEING
30 REVIEWED AND PROVIDE NOTIFICATION WITHIN THE FOLLOWING TIME

1 FRAMES :

2 (I) [A PROSPECTIVE UTILIZATION REVIEW DECISION SHALL BE
3 COMMUNICATED WITHIN TWO (2) BUSINESS DAYS OF THE RECEIPT OF ALL
4 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE
5 REVIEW.] A PROSPECTIVE UTILIZATION REVIEW OR PREAUTHORIZATION
6 DECISION SHALL BE RENDERED NOT MORE THAN SEVEN (7) DAYS AFTER
7 INITIAL SUBMISSION OF THE REQUEST FOR AUTHORIZATION. THE
8 DECISION TO AUTHORIZE OR DENY THE REQUESTED HEALTH CARE SERVICE
9 SHALL BE COMMUNICATED WITHIN FIVE (5) BUSINESS DAYS OF THE
10 RECEIPT OF ALL SUPPORTING INFORMATION REASONABLY NECESSARY TO
11 COMPLETE THE REVIEW. IF THE INITIAL SUBMISSION DOES NOT CONTAIN
12 ALL OF THE SUPPORTING INFORMATION REASONABLY NECESSARY TO
13 COMPLETE THE REVIEW, THE UTILIZATION REVIEW ENTITY MAY REQUEST
14 ADDITIONAL INFORMATION FROM THE PROVIDER BUT THE REQUEST SHALL
15 ONLY EXTEND THE SEVEN (7) DAY DEADLINE FOR A DECISION EITHER
16 AUTHORIZING OR DENYING THE HEALTH CARE SERVICE AN ADDITIONAL
17 FORTY-EIGHT (48) HOURS.

18 (II) A CONCURRENT UTILIZATION REVIEW DECISION SHALL BE
19 COMMUNICATED WITHIN ONE (1) BUSINESS DAY OF THE RECEIPT OF ALL
20 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE
21 REVIEW.

22 (III) A RETROSPECTIVE UTILIZATION REVIEW DECISION SHALL BE
23 COMMUNICATED WITHIN THIRTY (30) DAYS OF THE RECEIPT OF ALL
24 SUPPORTING INFORMATION REASONABLY NECESSARY TO COMPLETE THE
25 REVIEW. UTILIZATION REVIEW ENTITIES SHALL NOT RETROACTIVELY
26 REVIEW THE MEDICAL NECESSITY OF A PREAUTHORIZATION THAT HAS BEEN
27 PREVIOUSLY APPROVED OR GRANTED UNDER SECTION 2117.

28 (IV) A UTILIZATION REVIEW ENTITY SHALL ALLOW AN ENROLLEE AND
29 THE ENROLLEE'S HEALTH CARE PROVIDER A MINIMUM OF ONE (1)
30 BUSINESS DAY FOLLOWING AN INPATIENT ADMISSION UNDER EMERGENCY

1 HEALTH CARE SERVICE OR URGENT HEALTH CARE SERVICE TO NOTIFY THE
2 UTILIZATION REVIEW ENTITY OF THE ADMISSION AND ANY HEALTH CARE
3 SERVICES PERFORMED.

4 * * *

5 (6) PROVIDE ALL DECISIONS IN WRITING TO INCLUDE THE BASIS
6 AND CLINICAL RATIONALE FOR THE DECISION. FOR ADVERSE
7 DETERMINATIONS FROM PREAUTHORIZATION REQUESTS, A UTILIZATION
8 REVIEW ENTITY SHALL PROVIDE NOTICE OF ALL ADVERSE DETERMINATIONS
9 TO THE ENROLLEE AND THE ENROLLEE'S HEALTH CARE PROVIDER. THE
10 NOTICE OF ADVERSE DETERMINATION SHALL INCLUDE INSTRUCTIONS
11 CONCERNING HOW A GRIEVANCE MAY BE FILED FOR AN ADVERSE
12 DETERMINATION BASED ON MEDICAL NECESSITY. IF THE ADVERSE
13 DETERMINATION IS BASED ON AN ADMINISTRATIVE DEFECT, THE
14 DETERMINATION SHALL PROVIDE INFORMATION ON HOW THE DEFECT MAY BE
15 CURED AND INSTRUCTIONS FOR RESUBMITTING THE PREAUTHORIZATION
16 REQUEST.

17 * * *

18 (9) POST THE FOLLOWING TO THE UTILIZATION REVIEW ENTITY'S
19 PUBLICLY ACCESSIBLE INTERNET WEBSITE:

20 (I) A CURRENT LIST OF SERVICES AND SUPPLIES REQUIRING
21 PREAUTHORIZATION.

22 (II) WRITTEN CLINICAL CRITERIA FOR PREAUTHORIZATION
23 DECISIONS.

24 (10) ENSURE THAT A PREAUTHORIZATION SHALL BE VALID FOR NO
25 LONGER THAN ONE HUNDRED EIGHTY (180) DAYS OR THE DURATION OF
26 TREATMENT, WHICHEVER IS GREATER, FROM THE DATE THE HEALTH CARE
27 PROVIDER RECEIVES THE PREAUTHORIZATION SO LONG AS THE ENROLLEE
28 IS A MEMBER OF THE PLAN.

29 (11) WHEN PERFORMING PREAUTHORIZATION, ONLY REQUEST COPIES
30 OF MEDICAL RECORDS RELEVANT TO DETERMINING THE MEDICAL NECESSITY

1 OF A HEALTH CARE SERVICE REQUESTED.

2 (12) IN THE EVENT AN ADMINISTRATIVE DEFECT IS DISCOVERED, A
3 MANAGED CARE PLAN SHALL ALLOW A HEALTH CARE PROVIDER THE
4 OPPORTUNITY TO REMEDY THE ADMINISTRATIVE DEFECT WITHIN FORTY-
5 EIGHT HOURS (48) HOURS OF RECEIVING NOTICE OF THE DEFECT. IF A
6 HEALTH CARE PROVIDER REMEDIES THE ADMINISTRATIVE DEFECT, A
7 DETERMINATION OF PREAUTHORIZATION SHALL BE RENDERED WITHIN
8 FORTY-EIGHT (48) HOURS. IF THE ADMINISTRATIVE DEFECT REMAINS
9 UNCURED, THE MANAGED CARE PLAN MAY DENY PREAUTHORIZATION.

10 * * *

11 (E) FAILURE BY A UTILIZATION REVIEW ENTITY TO COMPLY WITH
12 DEADLINES AND OTHER REQUIREMENTS SPECIFIED FOR PREAUTHORIZATION
13 SHALL RESULT IN THE REQUESTED PREAUTHORIZATION FOR THE HEALTH
14 CARE SERVICE TO BE DEEMED AUTHORIZED AND PAID BY THE MANAGED
15 CARE PLAN. FAILURE OF THE PROVIDER CURE ANY ADMINISTRATIVE
16 DEFECTS IN PREAUTHORIZATION REQUESTS IN A TIMELY MANNER UNDER
17 THIS SECTION MAY RESULT IN THE PREAUTHORIZATION BEING DENIED.

18 SECTION 9. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:
19 SECTION 2161.1. INITIAL REVIEW OF PREAUTHORIZATION REQUESTS
20 AND ADVERSE DETERMINATIONS.--(A) A UTILIZATION REVIEW ENTITY
21 SHALL ENSURE THAT:

22 (1) A DENIAL BASED ON THE MEDICAL NECESSITY OF A
23 PREAUTHORIZATION REQUEST IS MADE BY A QUALIFIED LICENSED HEALTH
24 CARE PROVIDER WHO HAS KNOWLEDGE OF THE ITEMS, SERVICES,
25 PRODUCTS, TESTS OR PROCEDURES SUBMITTED FOR PREAUTHORIZATION.

26 (2) IF AN ADVERSE DETERMINATION IS MADE BY A PHYSICIAN AND
27 BASED ON MEDICAL NECESSITY, THEN THE PHYSICIAN MUST POSSESS A
28 CURRENT AND VALID NONRESTRICTED LICENSE TO PRACTICE MEDICINE IN
29 THIS COMMONWEALTH AND BE BOARD CERTIFIED. IF THE
30 PREAUTHORIZATION REVIEW REQUIRES A PEER-TO-PEER REVIEW IN THE

1 SPECIALTY OR SUBSPECIALTY WHERE A REVIEW IS REQUESTED BY THE
2 SUBMITTING PROVIDER, THEN THE PHYSICIAN CONDUCTING THE REVIEW ON
3 BEHALF OF THE UTILIZATION REVIEW ENTITY SHALL BE OF A SIMILAR
4 SPECIALTY TO THE HEALTH CARE SERVICE FOR WHICH PREAUTHORIZATION
5 IS REQUESTED.

6 (B) NOTIFICATION OF A PREAUTHORIZATION SHALL BE ACCOMPANIED
7 BY A UNIQUE PREAUTHORIZATION NUMBER AND INDICATE:

8 (1) THE SPECIFIC HEALTH CARE SERVICES PREAUTHORIZED.

9 (2) THE NEXT DATE FOR REVIEW.

10 (3) THE DATE OF ADMISSION OR INITIATION OF SERVICES, IF
11 APPLICABLE.

12 (C) IN THE EVENT A HEALTH CARE PROVIDER OBTAINS
13 PREAUTHORIZATION FOR ONE (1) SERVICE BUT THE SERVICE PROVIDED IS
14 NOT AN EXACT MATCH TO THE SERVICE THAT WAS PREAUTHORIZED A
15 UTILIZATION REVIEW ENTITY OR MANAGED CARE PLAN SHALL GRANT
16 AUTHORIZATION FOR THE HEALTH CARE SERVICE PROVIDED AND REMIT
17 PAYMENT AT A RATE OF REIMBURSEMENT THAT IS ASSOCIATED WITH
18 EITHER THE PREAUTHORIZED HEALTH CARE SERVICE OR THE SERVICE
19 APPROPRIATELY SUBSTITUTED BASED ON COMMON PROCEDURAL TERMINOLOGY
20 AND CLINICAL CRITERIA.

21 (D) (1) IF A UTILIZATION REVIEW ENTITY CHALLENGES THE
22 MEDICAL NECESSITY OF A HEALTH CARE SERVICE, THE UTILIZATION
23 REVIEW ENTITY SHALL NOTIFY THE ENROLLEE'S HEALTH CARE PROVIDER
24 THAT MEDICAL NECESSITY IS BEING CHALLENGED AND PROVIDE THE BASIS
25 OF THE CHALLENGE IN SUFFICIENT DETAIL TO ALLOW THE PROVIDER
26 REQUESTING AUTHORIZATION OF THE HEALTH CARE SERVICE TO
27 MEANINGFULLY ADDRESS THE CHALLENGE RAISED BY THE UTILIZATION
28 REVIEW ENTITY PRIOR TO ISSUING AN ADVERSE DETERMINATION.

29 (2) THE ENROLLEE'S HEALTH CARE PROVIDER OR DESIGNEE AND THE
30 ENROLLEE OR ENROLLEE'S DESIGNEE SHALL HAVE THE RIGHT TO DISCUSS

1 THE MEDICAL NECESSITY OF THE HEALTH CARE SERVICE WITH THE
2 UTILIZATION REVIEW PHYSICIAN.

3 (3) A UTILIZATION REVIEW ENTITY QUESTIONING MEDICAL
4 NECESSITY OF A HEALTH CARE SERVICE WHICH MAY RESULT IN AN
5 ADVERSE DETERMINATION SHALL ENSURE A REVIEWING PHYSICIAN MAKING
6 THE DECISION IS AVAILABLE TELEPHONICALLY AT A SPECIFICALLY
7 APPOINTED MUTUALLY AGREEABLE TIME SCHEDULED IN ADVANCE BETWEEN
8 THE PROVIDER REQUESTING THE HEALTH CARE SERVICE AND REVIEWING
9 PHYSICIAN BETWEEN THE HOURS OF SEVEN (7) O'CLOCK ANTEMERIDIAN
10 AND SEVEN (7) O'CLOCK POSTMERIDIAN. IF THE UTILIZATION REVIEW
11 ENTITY FAILS TO MAKE THE REVIEWING PHYSICIAN AVAILABLE AS
12 REQUIRED BY THIS PARAGRAPH, THE HEALTH CARE SERVICE SUBJECT TO
13 THE PREAUTHORIZATION REQUEST SHALL BE DEEMED AUTHORIZED.

14 (E) WHEN MAKING A DETERMINATION BASED ON MEDICAL NECESSITY,
15 A UTILIZATION REVIEW ENTITY SHALL BASE THE DETERMINATION ON AN
16 ENROLLEE'S PRESENTING SYMPTOMS, DIAGNOSIS AND INFORMATION
17 AVAILABLE THROUGH THE COURSE OF TREATMENT OR AT THE TIME OF
18 ADMISSION. SUCH INFORMATION MAY ALSO INCLUDE ANY MEDICAL
19 INFORMATION COLLECTED AT THE TIME THE ENROLLEE PRESENTED TO THE
20 EMERGENCY DEPARTMENT IF THE INFORMATION IS RELEVANT TO THE
21 DETERMINATION.

22 (F) IN THE EVENT A UTILIZATION REVIEW ENTITY DETERMINES AN
23 ALTERNATIVE LEVEL OF CARE IS APPROPRIATE, THE UTILIZATION REVIEW
24 ENTITY SHALL PROVIDE NOTICE OF THE ALTERNATIVE LEVEL OF CARE TO
25 THE PROVIDER REQUESTING PREAUTHORIZATION FOR A HEALTH CARE
26 SERVICE AND CITE THE SPECIFIC CRITERIA USED AS THE BASIS FOR THE
27 ALTERNATIVE LEVEL OF CARE DETERMINATION TO THE HEALTH CARE
28 PROVIDER PRIOR TO DENYING PREAUTHORIZATION. AN ALTERNATIVE LEVEL
29 OF CARE DECISION SHALL BE SUBJECT TO A PEER-TO-PEER REVIEW AS
30 UNDER THIS SECTION.

1 (G) A UTILIZATION REVIEW ENTITY MAY NOT ISSUE AN ADVERSE
2 DETERMINATION FOR A PROCEDURE DUE TO LACK OF PREAUTHORIZATION IF
3 THE PROCEDURE IS MEDICALLY NECESSARY OR CLINICALLY APPROPRIATE
4 FOR THE PATIENT'S MEDICAL CONDITION AND RENDERED AT THE SAME
5 TIME AS A RELATED PROCEDURE FOR WHICH PREAUTHORIZATION WAS
6 REQUIRED AND RECEIVED.

7 (H) A UTILIZATION REVIEW ENTITY SHALL MAKE A
8 PREAUTHORIZATION ADVERSE DETERMINATION DECISION AND NOTIFY THE
9 ENROLLEE AND THE ENROLLEE'S HEALTH CARE PROVIDER AS FOLLOWS:

10 (1) FOR NONURGENT HEALTH CARE SERVICES, WITHIN FIVE (5) DAYS
11 OF OBTAINING ALL THE NECESSARY INFORMATION TO MAKE THE
12 PREAUTHORIZATION OR ADVERSE DETERMINATION, SO LONG AS THE ENTIRE
13 REVIEW PROCESS IS COMPLETED EITHER SEVEN (7) DAYS FOLLOWING THE
14 INITIAL REQUEST IF NO ADDITIONAL INFORMATION IS REQUESTED BY THE
15 UTILIZATION REVIEW ENTITY OR NINE (9) DAYS FOLLOWING THE INITIAL
16 SUBMISSION IF ADDITIONAL INFORMATION IS REQUESTED.

17 (2) FOR URGENT HEALTH CARE SERVICES, WITHIN FORTY-EIGHT (48)
18 HOURS FROM SUBMISSION OF THE REQUEST FOR PRIOR AUTHORIZATION. NO
19 UTILIZATION REVIEW ENTITY MAY REQUIRE PREAUTHORIZATION FOR AN
20 EMERGENCY SERVICE, INCLUDING POST EVALUATION AND
21 POSTSTABILIZATION SERVICES.

22 SECTION 2161.2. PREAUTHORIZATION DENIAL GRIEVANCES.-- (A) AN
23 ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER MAY SUBMIT A
24 GRIEVANCE AND REQUEST AN EXPEDITED REVIEW OF AN ADVERSE
25 DETERMINATION VIA TELEPHONE, FACSIMILE, ELECTRONIC MAIL OR OTHER
26 METHOD. WITHIN ONE (1) DAY OF RECEIVING AN EXPEDITED REQUEST AND
27 ALL INFORMATION NECESSARY TO MAKE A DETERMINATION, THE
28 UTILIZATION REVIEW ENTITY SHALL PROVIDE THE ENROLLEE AND THE
29 ENROLLEE'S HEALTH CARE PROVIDER WRITTEN CONFIRMATION OF THE
30 EXPEDITED REVIEW DETERMINATION.

1 (B) A GRIEVANCE SHALL BE REVIEWED ONLY BY A PHYSICIAN WHO
2 SATISFIES ANY OF THE FOLLOWING CONDITIONS:

3 (1) IS BOARD CERTIFIED IN THE SAME SPECIALTY AS A HEALTH
4 CARE PRACTITIONER WHO TYPICALLY MANAGES THE MEDICAL CONDITION OR
5 DISEASE.

6 (2) IS CURRENTLY IN ACTIVE PRACTICE, PROVIDED THAT IN EVENTS
7 WHERE CIRCUMSTANCES JUSTIFY IT OR WHERE THE PROVIDER SEEKING
8 PREAUTHORIZATION SPECIFICALLY REQUESTS A HEALTH CARE PROVIDER
9 ACTIVELY ENGAGED IN THE SPECIALTY WHO TYPICALLY MANAGES THE
10 MEDICAL CONDITION OR DISEASE, THE PHYSICIAN SHALL BE MADE
11 AVAILABLE FOR THE REVIEW.

12 (3) IS KNOWLEDGEABLE OF, AND HAS EXPERIENCE IN, PROVIDING
13 THE HEALTH CARE SERVICES UNDER GRIEVANCE.

14 (4) IS UNDER CONTRACT WITH A UTILIZATION REVIEW ENTITY TO
15 PERFORM REVIEWS OF GRIEVANCES AND PAYMENT OF FEES DUE UNDER THE
16 CONTRACT, BUT THE PERFORMANCE AND PAYMENT IS NOT SUBJECT TO OR
17 CONTINGENT UPON THE OUTCOME OF THE APPEAL. THE FOLLOWING SHALL
18 APPLY:

19 (I) THE PHYSICIAN MAY ALSO BE SUBJECT TO A PROVIDER
20 AGREEMENT WITH THE MANAGED CARE PLAN AS A NETWORK PROVIDER, BUT
21 SHALL NOT RECEIVE ANY OTHER FEE OR COMPENSATION FROM THE MANAGED
22 CARE PLAN.

23 (II) THE PHYSICIAN'S RECEIPT OF COMPENSATION FROM EITHER THE
24 MANAGED CARE PLAN OR THE UTILIZATION REVIEW ENTITY SHALL NOT BE
25 CONSIDERED BY THE PHYSICIAN IN DETERMINING THE CONCLUSION
26 REACHED BY THE PHYSICIAN.

27 (III) THE PHYSICIAN SHALL AT ALL TIMES RENDER INDEPENDENT
28 AND ACCURATE MEDICAL JUDGMENT IN REACHING AN OPINION OR
29 CONCLUSION.

30 (IV) FAILURE TO COMPLY WITH THIS PROVISION SHALL RENDER THE

1 PHYSICIAN SUBJECT TO LICENSURE DISCIPLINARY ACTION BY THE
2 APPROPRIATE LICENSING BOARD.

3 (5) NOT INVOLVED IN MAKING THE ADVERSE DETERMINATION.

4 (6) FAMILIAR WITH ALL KNOWN CLINICAL ASPECTS OF THE HEALTH
5 CARE SERVICES UNDER REVIEW, INCLUDING ALL PERTINENT MEDICAL
6 RECORDS PROVIDED TO THE UTILIZATION REVIEW ENTITY BY THE
7 ENROLLEE'S HEALTH CARE PROVIDER AND ANY RELEVANT RECORD PROVIDED
8 TO THE UTILIZATION REVIEW ENTITY BY A HEALTH CARE FACILITY.

9 (C) THE UTILIZATION REVIEW ENTITY SHALL ENSURE THAT
10 GRIEVANCE REVIEW PROCEDURES SATISFY THE FOLLOWING REQUIREMENTS:

11 (1) THE ENROLLEE AND THE ENROLLEE'S HEALTH CARE PROVIDER MAY
12 CHALLENGE THE ADVERSE DETERMINATION AND HAVE THE RIGHT TO APPEAR
13 IN PERSON BEFORE THE UTILIZATION REVIEW ENTITY, INCLUDING THE
14 REVIEWING PHYSICIAN, WHO REVIEWS THE ADVERSE DETERMINATION.

15 (2) THE UTILIZATION REVIEW ENTITY SHALL PROVIDE THE ENROLLEE
16 AND THE ENROLLEE'S HEALTH CARE PROVIDER WRITTEN NOTICE OF THE
17 TIME AND PLACE CONCERNING WHERE THE REVIEW MEETING WILL TAKE
18 PLACE. NOTICE SHALL BE GIVEN TO THE ENROLLEE'S HEALTH CARE
19 PROVIDER AT LEAST FOURTEEN (14) DAYS IN ADVANCE OF THE REVIEW
20 MEETING.

21 (3) IF THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER
22 APPEAR IN PERSON, THE UTILIZATION REVIEW ENTITY SHALL OFFER THE
23 ENROLLEE OR ENROLLEE'S HEALTH CARE PROVIDER THE OPPORTUNITY TO
24 COMMUNICATE WITH THE REVIEWING PHYSICIAN, AT THE UTILIZATION
25 REVIEW ENTITY'S EXPENSE, BY CONFERENCE CALL, VIDEO CONFERENCING
26 OR OTHER AVAILABLE TECHNOLOGY.

27 (4) THE PHYSICIAN PERFORMING THE REVIEW OF THE GRIEVANCE
28 SHALL CONSIDER ALL INFORMATION, DOCUMENTATION OR OTHER MATERIAL
29 SUBMITTED IN CONNECTION WITH THE GRIEVANCE WITHOUT REGARD TO
30 WHETHER THE INFORMATION WAS CONSIDERED IN MAKING THE ADVERSE

1 DETERMINATION.

2 (D) THE FOLLOWING DEADLINES SHALL APPLY TO THE UTILIZATION
3 REVIEW ENTITIES:

4 (1) A UTILIZATION REVIEW ENTITY SHALL DECIDE A GRIEVANCE
5 SUBMITTED FOR EXPEDITED REVIEW AND NOTIFY THE ENROLLEE AND THE
6 ENROLLEE'S HEALTH CARE PROVIDER OF THE DETERMINATION WITHIN TWO
7 (2) DAYS AFTER RECEIVING A NOTICE OF THE EXPEDITED REVIEW
8 REQUEST BY THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER
9 AND ALL INFORMATION NECESSARY TO RENDER A DECISION.

10 (2) A UTILIZATION REVIEW ENTITY SHALL ISSUE A WRITTEN
11 DETERMINATION CONCERNING A NONEXPEDITED GRIEVANCE NOT LATER THAN
12 THIRTY (30) DAYS AFTER RECEIVING A NOTICE OF THE GRIEVANCE FROM
13 AN ENROLLEE OR ENROLLEE'S HEALTH CARE PROVIDER.

14 (E) WRITTEN NOTICE OF FINAL AN ADVERSE DETERMINATION SHALL
15 BE PROVIDED TO THE ENROLLEE AND THE ENROLLEE'S HEALTH CARE
16 PROVIDER.

17 (F) IF THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER
18 OR A DESIGNEE ON BEHALF OF EITHER THE ENROLLEE OR THE ENROLLEE'S
19 HEALTH CARE PROVIDER HAS SATISFIED ALL NECESSARY REQUIREMENTS
20 FOR THE GRIEVANCE REVIEW DETERMINATION OF AN ADVERSE
21 DETERMINATION THROUGH THE PREAUTHORIZATION PROCESS AND THE
22 DETERMINATION HAS RESULTED IN A CONTINUED ADVERSE DETERMINATION
23 EITHER BASED ON LACK OF MEDICAL NECESSITY OR AN ADMINISTRATIVE
24 DEFECT, THE ENROLLEE, THE ENROLLEE'S HEALTH CARE PROVIDER OR A
25 DESIGNEE ON BEHALF OF EITHER THE ENROLLEE OR THE ENROLLEE'S
26 HEALTH CARE PROVIDER OR A DESIGNEE MAY FILE A CONSUMER COMPLAINT
27 WITH THE DEPARTMENT OF HEALTH IF FOR CONTINUED LACK OF MEDICAL
28 NECESSITY AND THE INSURANCE DEPARTMENT IF FOR ADMINISTRATIVE
29 DEFECT. THE COMPLAINT SHALL BE ADJUDICATED WITHOUT UNNECESSARY
30 DELAY IN ACCORDANCE WITH CURRENT LAW AND A DETERMINATION ISSUED

1 BY THE RELEVANT DEPARTMENT WITH APPROPRIATE SANCTIONS, IF
2 APPLICABLE, UNDER THE AUTHORITY GIVEN TO THAT DEPARTMENT.

3 (G) TO THE EXTENT THAT AN ENROLLEE, AN ENROLLEE'S HEALTH
4 CARE PROVIDER OR A DESIGNEE ON BEHALF OF EITHER THE ENROLLEE OR
5 THE ENROLLEE'S HEALTH CARE PROVIDER OR A DESIGNEE FILES A
6 CONSUMER COMPLAINT WITH EITHER DEPARTMENT OR THE OFFICE OF
7 ATTORNEY GENERAL UNDER THE AUTHORITY TO RECEIVE THE COMPLAINTS,
8 A COPY OF THE COMPLAINT FILED WITH EITHER DEPARTMENT OR THE
9 OFFICE OF ATTORNEY GENERAL SHALL BE FORWARDED TO THE INSURANCE
10 DEPARTMENT AND THE COPY SHALL SERVE AS A NEW CONSUMER COMPLAINT
11 TO BE ADJUDICATED UNDER THE TERMS OF THIS SECTION AND ALL OTHER
12 APPLICABLE LAW.

13 SECTION 2195. ACCESS REQUIREMENTS IN SERVICE AREAS.--IF AN
14 ENROLLEE'S SAFE DISCHARGE IS DELAYED FOR ANY REASON, INCLUDING
15 LACK OF AVAILABLE POSTHOSPITALIZATION SERVICES, INCLUDING
16 SKILLED NURSING FACILITIES, HOME HEALTH SERVICES AND POSTACUTE
17 REHABILITATION, THE MANAGED CARE PLAN SHALL REIMBURSE THE
18 HOSPITAL FOR EACH SUBSEQUENT DATE OF SERVICE AT THE GREATER OF
19 THE CONTRACTED RATE WITH THE MANAGED CARE PLAN FOR THE CURRENT
20 LEVEL OF CARE AND SERVICE OR THE FULL DIAGNOSTIC RELATED GROUP
21 PAYMENT DIVIDED BY THE MEAN LENGTH OF STAY FOR THE PARTICULAR
22 DIAGNOSTIC RELATED GROUP.

23 SECTION 11. NOTHING IN THIS ACT SHALL BE CONSTRUED TO
24 PRECLUDE AN INSURER FROM DEVELOPING A PROGRAM EXEMPTING A HEALTH
25 CARE PROVIDER FROM PREAUTHORIZATION PROTOCOLS.

26 SECTION 12. THIS ACT SHALL TAKE EFFECT IN 60 DAYS.