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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1847 Session of 1995

INTRODUCED BY KUKOVICH, KING, THOMAS, BELARDI, CURRY, MELIO, DeWEESE, MIHALICH, STEELMAN, MANDERINO, STURLA, STABACK, MUNDY, HALUSKA, JOSEPHS, YOUNGBLOOD, RICHARDSON, TRELLO, PISTELLA AND MICHLOVIC, JUNE 21, 1995

REFERRED TO COMMITTEE ON INSURANCE, JUNE 21, 1995

AN ACT

Providing for certain regulation of health care utilization review, for additional duties of the Insurance Commissioner and the Insurance Department, for the certification of review agencies, for review plans and standards, for grievance and other procedures and for penalties.

The General Assembly finds and declares as follows:

(1) That health, mental health and substance abuse patients are being denied care as the result of utilization review, which process may lack communication between reviewer and care provider, timeliness, objective peer review based on generally accepted treatment standards, consideration of appropriateness of care, provider knowledge of review standards, consistency and relevance of protocol or a meaningful appeal process, as the result of using economic factors to determine availability of benefits.

(2) That this act is intended to promote the delivery of quality health, mental health and substance abuse care in a cost-effective manner; foster greater coordination among

health, mental health and substance abuse care providers, third-party payors and others who conduct utilization review; protect patients, employers and health, mental health and substance abuse care providers by ensuring that review agents and review agencies are qualified to perform utilization review and to make informed decisions on the appropriateness of health, mental health and substance abuse care; protect patients' health care interests through public access to the written criteria and standards used in utilization review; and ensure the confidentiality of patients' health or medical records in the utilization review process in accordance with applicable Federal and State laws.

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

Section 1. Short title.

This act shall be known and may be cited as the Certification and Regulation of Utilization Review Act.

Section 2. Definitions.

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

"Certification." Certification granted by the Insurance Commissioner to a review agent or to a review agency under this act.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Health care provider." A person, corporation, facility or institution licensed or regulated by the Commonwealth to provide health, mental health or substance abuse services, including,

but not limited to, hospital or other health care facility, physician, osteopathic physician, nurse practitioner, certified nurse-midwife, psychologist, social worker or an officer or employee of a health care provider acting in the course and scope of his employment.

"Health, mental health and substance abuse care services." Acts of diagnosis, treatment, evaluation or advice or other acts as may be permissible under the health care professional licensing statutes of the Commonwealth.

"Review agency." An entity or person performing utilization review that is either employed by, affiliated with, contracted by or acting on behalf of:

(1) a business entity doing business in this Commonwealth; or

(2) a third party which provides or administers hospital, health, mental health or substance abuse care benefits to persons in this Commonwealth, including, but not limited to, a health insurer, nonprofit health service plan, health service organization, health maintenance organization or preferred provider organization or any other entity authorized to offer health, mental health or substance abuse benefits in this Commonwealth.

"Review agent." A person who is employed by a review agency to perform utilization review and who meets the standards under section 5(1).

"Utilization review." Review of the appropriate or efficient allocation of hospital, medical or other health care services given or proposed to be given to an enrollee or group of enrollees for the purpose of recommending or determining whether such services should be reimbursed, covered or provided by a

health care coverage plan. The term includes, but is not limited to, site of service or preadmission review, preprocedure or treatment review, prereferral review, length of stay, continued stay or concurrent review, second opinions, point-of-sale drug utilization review, retrospective review and case management. The term does not include review performed solely for educational purposes.

"Utilization review plan." The criteria and standards governing utilization review performed by a review agent.

Section 3. Certification.

(a) Certification required.--A review agent or review agency which approves or denies payment or services or which recommends approval or denial of payment for inpatient or outpatient health, mental health or substance abuse services shall not conduct utilization review unless the department has granted the review agent or the review agency certification under this act.

(b) Application.--A review agent or review agency shall file an application for certification with the department on forms prescribed by the commissioner and shall pay a filing fee established by the commissioner. Certification shall be renewed biennially and shall not be transferable.

(c) Additional information.--As part of the application, the review agent shall submit information required by the commissioner, including, but not limited to, a certification that there is no direct or indirect financial incentive that could influence a utilization review determination by the review agent. The information shall include a statement of the amount and method of payment for utilization review services to be performed by the review agent.

(d) Plans, materials, etc.--As part of the application, the

review agency shall submit information required by the commissioner, including, but not limited to:

(1) A utilization review plan that includes specific review standards, criteria and procedures to be used in evaluating delivered or proposed health, mental health or substance abuse services and the citations to the scientific literature relied upon in establishing these standards, criteria and procedures.

(2) A copy of the materials designed to inform applicable patients and health care providers of the requirements and appeals process of the utilization review plan, including release of information forms to be signed by patients, permitting the review agency to engage in review with the health care provider. Release of information forms for psychiatric, substance abuse and HIV-related patients must be in compliance with Federal and State requirements.

(3) A list of the business entities, insurance companies providing payment for health care services or any other third-party payors for which the review agency is performing utilization review in this Commonwealth, a brief description of the specific services it is providing for each of them and a statement verifying there is no payment system containing an incentive or contingent fee arrangement.

(4) An identification of every person and business entity, no matter how organized, which has a financial interest in the review agency and the amount and nature of the financial interest.

(5) A certification that any subcontractor which is incorporated or located outside the boundaries of this Commonwealth agrees to comply with all the provisions of this

act as well as with all Commonwealth professional licensing statutes and relevant regulations.

(e) Fees.--The filing fees required under subsection (b) shall be sufficient to pay for the administrative costs of the certification program and any other costs associated with carrying out the provisions of this act.

Section 4. Disclosure of complaints, grievances and inquiries.

The commissioner shall require applicants for certification and for renewal of certification to submit a list of all complaints, grievances and inquiries requiring corrective action submitted to the review agent or review agency by patients or health care providers with respect to the utilization review plan or the review agent's or review agency's performance of utilization review and a description of how the complaints, grievances and inquiries requiring corrective action were resolved.

Section 5. Standards.

The commissioner shall adopt standards by promulgating regulations within six months of the effective date of this act, establishing the following requirements:

(1) That review agents performing reviews shall be licensed in the same profession and have the same specialty or subspecialty as the patient's attending health care provider, except that a review agency may use a licensed registered nurse or a licensed practical nurse for first-level review if the first-level reviewer has recent clinical experience and utilization review training as defined by the regulations. No first-level reviewer shall deny authorization for treatment. The review agency shall have procedures in place which properly identify the review agent to the

attending health care provider and which provide information to the attending health care provider regarding the professional credentials and qualifications of the reviewer.

(2) That the review agency provide health care providers and patients in language which is written, organized and designed so as to be easy to read and understand, with its utilization review plan and appeals process, including the specific review criteria and standards, procedures and methods to be used in evaluating proposed or delivered inpatient or outpatient health, mental health or substance abuse services. These plans shall be consistent with utilization review standards developed by the relevant national specialty or professional organizations where they exist.

(3) That any determination regarding inpatient or outpatient or other health, mental health or substance abuse services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service shall include the evaluation, findings and concurrence of a professional who is trained, certified and licensed in this Commonwealth and experienced in the relevant specialty or subspecialty.

(4) That any determination that care rendered or to be rendered is inappropriate shall not be made until a review agent has spoken to the patient's attending health care provider concerning the care.

(5) That the complete utilization review shall be provided to the health care provider in writing, including the written evaluation and findings of the review agent, prior to the report being deemed final for purposes of

limited approval or denial of benefits or for any determination that care rendered or to be rendered is inappropriate.

(6) That health care providers shall not be prohibited from discussing with the patient the utilization review process and determinations or the right to request further appeals or an administrative law judge hearing.

(7) That a review agent is reasonably accessible to health care providers at least five days a week during normal business hours and that payment may not be denied for treatment rendered during a period when the review agent is not available.

(8) That policies and procedures to ensure that all applicable Federal and State laws to protect the confidentiality of individual treatment records are followed. This protection shall include assurance that any procedures developed by the review agency pertaining to utilization review shall not interfere with the treatment process. The release of confidential patient information by the attending health care provider to the review agent or review agency shall be limited only to that information which is reasonable and pertinent to determining the necessity of the services under review. The review shall be kept confidential by the review agent and the review agency pursuant to the ethical principles and laws that pertain to the health care provider's obligation to protect patients. All information released to the review agent and the review agency shall require the patient's signed, informed consent, except that no benefits shall be denied solely on the grounds that the patient has refused to give signed consent based on religious

beliefs.

(9) That a review agent shall not be permitted to enter a hospital or other treatment setting to interview or examine a patient unless the interview or examination is consistent with Federal and State laws regarding confidentiality and with provider policies.

(10) The circumstances under which utilization review may be delegated to a hospital utilization review program.

(11) The prohibition of a contract provision between the review agency and a business entity or third-party payor in which payment to the review agency includes an incentive or contingent fee arrangement based on the treatment, philosophy or type being selected, reduction of health care services, reduction of length of stay, reduction of treatment or the denial of treatment.

(12) That the medical practitioner acting as review agent is deemed to be engaged in the practice of medicine, consistent with the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or section 2 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, and is therefore legally liable for the consequences of any decision affecting patient care.

(13) The professional credentials and qualifications of a review agent.

(14) The qualifications of a review agency.

(15) That benefits cannot be denied solely on the grounds that the patient has been diagnosed with a specific type of illness, meets the standards leading to treatment for detoxification from alcohol and other drugs, is referred as

the result of having been convicted of a criminal offense or is committed by a court for psychiatric evaluation and/or treatment.

(16) That detoxification and involuntary psychiatric commitments shall be considered emergencies for purposes of this act, and that prior to any emergency admission, precertification shall not be required.

(17) That benefits shall be paid from the onset of services through appeal and shall continue thereafter if the decision on appeal is in favor of the patient or provider.

(18) That decisions of a review agent on behalf of a review agency regarding continuing care shall be made as follows:

(i) For inpatient care, not less than three working days before the last certified day of treatment.

(ii) For outpatient care, not less than one working day before the last certified day of treatment.

(iii) For outpatient psychiatric care or substance abuse treatment, not less than 20 working days before the last certified day of treatment.

(19) That the review agency submit to the commissioner information detailing its procedures for appealing adverse determinations, including, but not limited to, the following:

(i) The review agency shall establish an appeals committee in which the majority of the members shall be composed of health care providers who are licensed or certified in this Commonwealth in the same discipline as the service being reviewed and which includes a past consumer of comparable or similar services.

(ii) Adverse decisions shall be communicated to the

aggrieved party and the provider in writing with supporting reasons for noncertification or denial within a reasonable time frame. Those time frames shall include:

(A) For inpatient reviews, within two working days.

(B) For outpatient reviews, within seven working days.

(iii) The review agency shall provide an opportunity for the appellant to be physically present at an appeals hearing and to be accompanied by legal counsel and a treatment advocate or specialist to present additional evidence for consideration by the appeals committee. Before rendering a final decision, the committee shall review the pertinent medical records of the insured's health care provider and the pertinent records of any facility in which health care is provided to the insured.

(iv) In the appeals process, due consideration shall be given to the availability or nonavailability of optional health care services proposed by the review agency.

(v) The aggrieved party shall have the opportunity to file a complaint and obtain administrative relief in response to a decision of the review agency regarding grievance and appeal results.

(vi) Reconsiderations on appeal shall not be performed by the same review agent or professional who conducts the initial review.

(vii) Providers shall be reimbursed for the cost of photocopies of medical records made available on appeal at not less than the current Medicare photocopying

reimbursement rate and for the cost of postage related to the provision of such records.

(viii) The purchaser of utilization review services shall pay all costs associated with the initial review. The review agency may also require the purchaser to pay a reasonable charge for appeal or reconsideration of an adverse decision, except that the charge shall not be more than the charge for the initial review, and the charge for appeal or reconsideration shall be ultimately borne by the party against whom the decision on appeal or reconsideration is made.

Section 6. Appeal to department.

An aggrieved patient or health care provider may file a complaint with the commissioner alleging that a review agent or review agency is not in compliance with this act or the regulations adopted pursuant thereto and requesting that the commissioner require that the review agent or review agency comply with the act or regulations or that the commissioner revoke or suspend the certification of the review agent or review agency. The commissioner's decision with respect to the complaint shall be subject to a review by an administrative law judge upon appeal by the patient, health care provider or review agent. The commissioner shall render a decision upon a complaint brought by a patient or health care provider within 60 days.

Section 7. Denial, suspension or revocation.

(a) Grounds for denial.--The commissioner shall deny certification to a review agent or review agency whose application fails to:

(1) Provide information required by this act and regulations adopted under this act.

(2) Provide satisfactory assurance of the ability to comply with this act and regulations adopted under this act.

(3) In the case of a review agency, demonstrate the availability of a sufficient number of qualified and credentialed review agents to carry out timely utilization review activities.

(b) Suspension and revocation.--The commissioner may suspend or revoke certification if the certificate holder violates any provision of this act or violates any regulation adopted under this act.

(c) Procedure.--The following procedural requirements shall govern the denial, suspension or revocation of certification:

(1) Before denying, suspending or revoking certification, the commissioner shall provide an applicant or certificate holder with reasonable time, not to exceed 90 days, to supply additional information demonstrating compliance with the requirements of this act.

(2) An applicant or certificate holder shall have the opportunity to request a hearing. If a request for a hearing is made, the commissioner shall send the applicant or certificate holder a hearing notice by certified mail, return receipt requested, at least 30 days before the hearing. The hearing shall be held pursuant to 2 Pa.C.S. (relating to administrative law and procedure).

(3) Nothing in this section shall be deemed to deprive a patient or health care provider of any other cause of action available under State law.

Section 8. Reporting requirements.

The commissioner shall establish reporting requirements for review agents and review agencies to evaluate their

effectiveness and to determine whether the utilization review programs are in compliance with this act. The evaluation shall include, but not be limited to, the number and appropriateness of denials of health, mental health and substance abuse benefits and the percentage of total claims these denials represent. In addition, applicants for renewal of certification may be required to report information which would allow the utilization review plan to be evaluated against performance standards or quality assurance measures which the commissioner may establish.

Section 9. Confidentiality.

A review agent or review agency or any of its employees shall not disclose, redisclose or publish individual treatment records or any other health or medical information obtained in the performance of review activities.

Section 10. Enforcement.

(a) Injunctive relief.--A person alleging a violation of this act shall have a cause of action in a court of competent jurisdiction for injunctive relief and damages.

(b) Damages, costs, etc.--A review agent or review agency which violates any provision of this act is liable for actual damages for economic, bodily or emotional harm sustained as a result of the violation, punitive damages as allowed by a court or jury and the costs of the action, together with reasonable attorney fees.

(c) Civil penalty.--In addition to any other penalties, a report of a violation of this act may be made by any party and directed to the commissioner, who may assess a civil penalty for the violation in an amount of not more than $1,000 in the case of a first violation and not more than $5,000 in the case of each subsequent violation. The civil penalty shall be paid to

the insured, and the review agent or review agency shall be liable for the costs of the action, together with reasonable attorney fees.

Section 11. Regulations.

The commissioner shall promulgate rules and regulations necessary to carry out the provisions of this act within one year of the effective date of this act.

Section 12. Report to Governor and General Assembly.

The commissioner shall issue an annual report to the Governor and the General Assembly concerning the conduct of utilization review in this Commonwealth. The report shall include a description of utilization review programs and the services they provide, the type of written criteria and standards used to perform utilization review, the feasibility of utilization review, an analysis of the complaints filed against review agents and review agencies by patients and by health care providers and an evaluation of the impact of utilization review programs on patient access to appropriate care and treatment outcomes.

Section 13. Applicability.

This act shall apply to health care utilization review employed by any health care insurer operating under any one of the following:

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

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

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

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

40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

Section 14. Effective date.

This act shall take effect immediately.