
THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1293 Session of
2017

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SAYLOR, SOLOMON, STURLA, WARD, WARREN, WATSON, WHEELAND AND
SIMS, MAY 1, 2017

REFERRED TO COMMITTEE ON INSURANCE, MAY 1, 2017

AN ACT

1 Providing for preauthorizations conducted by utilization review
2 entities relating to health care services.

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

5 Section 1. Short title.

6 This act shall be known and may be cited as the Utilization
7 Review Entity Preauthorization Act.

8 Section 2. Declaration of policy.

9 The General Assembly finds and declares as follows:

10 (1) The health care practitioner-patient relationship is
11 paramount and should not be subject to third-party intrusion.

12 (2) Preauthorization programs should not be permitted to
13 hinder patient care or intrude on the practice of medicine.

14 (3) Preauthorization programs must include the use of
15 independently developed, evidence-based and, when necessary

1 or available, appropriate use criteria or written clinical
2 criteria.

3 (4) Preauthorization programs must include reviews by
4 appropriate physicians to ensure a fair process for patients.

5 Section 3. Definitions.

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

9 "Adverse determination." A decision by a utilization review
10 entity that:

11 (1) The health care services furnished or proposed to be
12 furnished to a subscriber are not medically necessary or are
13 experimental or investigational.

14 (2) Denies, reduces or terminates benefit coverage.
15 The term does not include a decision to deny, reduce or
16 terminate services which are not covered for reasons other than
17 their medical necessity or experimental or investigational
18 nature.

19 "Appeal." A formal request, either orally or in writing, to
20 reconsider a determination not to preauthorize a health care
21 service.

22 "Appeals procedure." A formal process that permits a
23 subscriber, attending physician or his designee, facility or
24 health care practitioner on a subscriber's behalf, to appeal an
25 adverse determination rendered by the utilization review entity
26 or its designee utilization review entity or agent.

27 "Appropriate use criteria." Criteria that:

28 (1) defines when and how often it is medically necessary
29 and appropriate to perform a specific test or procedure; and

30 (2) is derived from documents from professional

1 societies that are evidence-based or, when evidence is
2 conflicting or lacking, from expert consensus panels and
3 which documents include published clinical guidelines for
4 appropriate use for the specific clinical scenario under
5 consideration.

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

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

12 (2) payment will be made for the health care service.

13 "Clinical criteria." The written policies, written screening
14 procedures, determination rules, determination abstracts,
15 clinical protocols, practice guidelines and medical protocols
16 used by a utilization review entity to determine the necessity
17 and appropriateness of health care services.

18 "Emergency health care services." Health care services that
19 are provided in a hospital emergency facility after the sudden
20 onset of a medical condition that manifests itself by symptoms
21 of sufficient severity, including severe pain, that the absence
22 of immediate medical attention could reasonably be expected by a
23 prudent layperson, who possesses an average knowledge of health
24 and medicine, to result in:

25 (1) placing the patient's health in serious jeopardy;

26 (2) serious impairment to bodily function; or

27 (3) serious dysfunction of a bodily organ or part.

28 "Expedited appeal." A formal request, either orally or in
29 writing, to reconsider an adverse determination not to authorize
30 emergency health care services or urgent health care services.

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

4 "Health care practitioner." As defined in section 103 of the
5 act of July 19, 1979 (P.L.130, No.48), known as the Health Care
6 Facilities Act.

7 "Health care service." Health care procedures, treatments or
8 services provided by or within:

- 9 (1) a facility licensed in this Commonwealth;
- 10 (2) a doctor of medicine or a doctor of osteopathy; or
- 11 (3) the scope of practice for which a health care
12 practitioner is licensed in this Commonwealth.

13 The term includes the provision of pharmaceutical products or
14 services or durable medical equipment.

15 "Medically necessary health care services." Health care
16 services that a prudent health care practitioner would provide
17 to a patient for the purpose of preventing, diagnosing or
18 treating an illness, injury, disease or its symptoms in a manner
19 that is:

- 20 (1) in accordance with generally accepted standards of
21 medical practice;
- 22 (2) clinically appropriate in terms of type, frequency,
23 extent, site and duration; and
- 24 (3) not primarily for the economic benefit of the health
25 plans and purchasers or for the convenience of the patient,
26 treating physician or other health care practitioner.

27 "NCPDP SCRIPT Standard." The National Council for
28 Prescription Drug 10 Programs SCRIPT Standard Version 201310,
29 the most recent standard adopted by the Department of Health and
30 Human Services or a subsequently released version, provided that

1 the new version of the standard is backwards-compatible to the
2 current version adopted by the Department of Health and Human
3 Services.

4 "Preauthorization." The process by which a utilization
5 review entity determines the medical necessity or medical
6 appropriateness of otherwise covered health care services prior
7 to authorizing coverage and the rendering of the health care
8 services, including, but not limited to, preadmission review,
9 pretreatment review, utilization and case management. The term
10 includes a health insurer's or utilization review entity's
11 requirement that a subscriber or health care practitioner notify
12 the health insurer or utilization review agent prior to
13 providing a health care service.

14 "Retrospective review." The review of the medical necessity
15 and appropriateness of health care services provided to a
16 subscriber, the performance of which review occurs for the first
17 time subsequent to the completion of the health care services.

18 "Subscriber." An individual who is eligible to receive
19 health care benefits by a health insurer pursuant to a health
20 plan or other health insurance coverage. The term includes such
21 individual's legally authorized representative.

22 "Urgent health care service." A health care service with
23 respect to which the application of the time periods for making
24 a nonexpedited preauthorization, in the opinion of a health care
25 practitioner with knowledge of a subscriber's medical condition
26 could:

27 (1) seriously jeopardize the life or health of the
28 subscriber or the ability of the subscriber to regain maximum
29 function; or

30 (2) subject the subscriber to severe pain that cannot be

1 adequately managed without the care or treatment that is the
2 subject of the utilization review.

3 "Utilization review entity." An individual or entity that
4 performs preauthorization for one or more of the following
5 entities:

6 (1) an employer with employees in this Commonwealth who
7 are covered under a health benefit plan or health insurance
8 policy;

9 (2) an insurer that writes health insurance policies;

10 (3) a preferred provider organization or health
11 maintenance organization; and

12 (4) any other individual or entity that provides, offers
13 to provide or administers hospital, outpatient, medical or
14 other health benefits to an individual treated by a health
15 care practitioner in this Commonwealth under a policy, plan
16 or contract.

17 The term includes a health insurer if the health insurer
18 performs preauthorization.

19 Section 4. Basis, development and use.

20 (a) Electronic communications network required.--No later
21 than 180 days after the effective date of this act, prior
22 authorization requests shall be accessible to health care
23 practitioners and accepted by insurers, pharmacy benefits
24 managers and utilization review organizations electronically
25 through a secure electronic transmission using the NCPDP SCRIPT
26 Standard electronic prior authorization transactions. Facsimile,
27 proprietary payer portals and electronic forms shall not be
28 considered electronic transmissions.

29 (b) Preauthorization restrictions to be based on written
30 clinical criteria.--Any restrictions that a utilization review

1 entity places on the preauthorization of health care services
2 shall be:

3 (1) Based on the medical necessity or appropriateness of
4 those services and on written clinical criteria.

5 (2) Applied consistently.

6 (c) Adverse determinations and final adverse determinations
7 to be based on written clinical criteria.--Adverse
8 determinations and final adverse determinations made by a
9 utilization review agent must be based on written clinical
10 criteria.

11 (d) Lack of evidence-based and expert consensus standards.--
12 If no independently developed, evidence-based standards derived
13 from documents from professional societies, or when evidence-
14 based standards are conflicting or lacking from expert consensus
15 panels, exist for a particular health care item, service,
16 pharmaceutical product, test or imaging procedure, the
17 utilization review entity may not deny coverage of the health
18 care item, service, pharmaceutical product, test or imaging
19 procedure based solely on the grounds that the health care item,
20 service, pharmaceutical product, test or imaging procedure does
21 not meet an evidence-based standard.

22 (e) The basis of clinical criteria and expert consensus.--
23 Written clinical criteria shall:

24 (1) Be based on nationally recognized standards.

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

27 (3) Reflect community standards of care.

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

30 (5) Be evidence-based or based on generally accepted

1 expert consensus standards.

2 (6) Be sufficiently flexible to allow deviations from
3 norms when justified on case-by-case basis.

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

6 (f) Preauthorization not required.--Preauthorization shall
7 not be required:

8 (1) where a medication or procedure prescribed for a
9 patient is customary and properly indicated or is a treatment
10 for the clinical indication as supported by peer-reviewed
11 medical publications; or

12 (2) for a patient currently managed with an established
13 treatment regimen.

14 (g) Electronic standards for prior authorization.--No later
15 than 180 days after the effective date of this section, the
16 payer shall accept and respond to prior authorization requests
17 under the pharmacy benefit through a secure electronic
18 transmission using the NCPDP SCRIPT Standard ePA transactions.

19 (h) Appropriate use of step therapy protocols.--A
20 utilization review entity shall not:

21 (1) Require a health care practitioner offering services
22 to a subscriber to participate in a step 1 therapy protocol
23 if the practitioner deems that the step 1 therapy protocol is
24 not in the patient's best interests.

25 (2) Require that a health care practitioner first obtain
26 a waiver, exception or other override when deeming a step 1
27 therapy protocol not to be in a patient's best interests.

28 (3) Sanction or otherwise penalize a health care
29 practitioner for recommending or issuing a prescription,
30 performing or recommending a procedure or performing a test

1 that may conflict with the step 1 therapy protocol of the
2 health insurer or health insurance plan.

3 Section 5. Mandatory disclosure and review of preauthorization
4 requirements and restrictions.

5 (a) Disclosure.--A utilization review entity shall post to
6 its publicly accessible Internet website:

7 (1) A current list of services and supplies requiring
8 preauthorization.

9 (2) Written clinical criteria for preauthorization
10 decisions.

11 (b) Specific notice to contracted health care
12 practitioners.--If a utilization review entity intends to
13 implement a new preauthorization requirement or restriction or
14 to amend an existing requirement or restriction, the utilization
15 review entity shall provide contracted health care practitioners
16 written notice of the new or amended requirement or amendment
17 not less than 60 days before the requirement or restriction is
18 implemented.

19 (c) Length of prior authorization.--A prior authorization
20 shall be valid for one year from the date the health care
21 practitioner receives the prior authorization.

22 Section 6. Personnel qualified to make preauthorizations and
23 adverse determinations.

24 A utilization review entity shall ensure that:

25 (1) Preauthorizations are made by a qualified licensed
26 health care practitioner.

27 (2) Adverse determinations are made by a physician. The
28 reviewing physician must possess a current and valid
29 nonrestricted license to practice medicine in this
30 Commonwealth.

1 Section 7. Utilization review entity duties in
2 preauthorizations or nonurgent circumstances.

3 (a) Deadline.--If a health insurer requires preauthorization
4 of a health care item, service, pharmaceutical product, test or
5 imaging procedure, the utilization review entity shall make a
6 preauthorization or adverse determination and notify the
7 subscriber and the subscriber's health care practitioner within
8 two business days of obtaining all necessary information to make
9 the preauthorization or adverse determination.

10 (b) Requirements specific to notices of preauthorization.--
11 Notifications of preauthorizations shall be accompanied by a
12 unique preauthorization number and indicate:

13 (1) The specific health care services preauthorized.

14 (2) The next date for review.

15 (3) The total number of days approved.

16 (4) The date of admission or initiation of services, if
17 applicable.

18 (c) Binding nature of prior approvals.--Neither the
19 utilization review entity nor the payer or health insurer that
20 has retained the utilization review entity may retroactively
21 deny coverage for emergency or nonemergency care that had been
22 preauthorized when it was provided, if the information provided
23 was accurate.

24 (d) Consultation prior to issuing an adverse
25 determination.--

26 (1) If a utilization review entity questions the medical
27 necessity of a health care service, the utilization review
28 entity shall notify the subscriber's health care practitioner
29 that medical necessity is being questioned prior to issuing
30 an adverse determination.

1 (2) The subscriber's health care practitioner and the
2 subscriber's designee shall have the right to discuss the
3 medical necessity of the health care service with the
4 utilization review physician.

5 Section 8. Utilization review entity duties relating to urgent
6 health care services.

7 (a) Deadline.--A utilization review entity shall render a
8 preauthorization or adverse determination concerning urgent care
9 services and notify the subscriber's health care practitioner of
10 the preauthorization or adverse determination not later than one
11 business day after receiving all information needed to complete
12 the review of the requested health care services.

13 (b) Availability of physician rendering adverse
14 determination to subscriber's health care practitioner.--

15 (1) If a utilization review entity questions the medical
16 necessity of an urgent health care service, the utilization
17 review entity shall notify the subscriber's health care
18 practitioner that medical necessity is being questioned.

19 (2) Prior to issuing an adverse determination, the
20 utilization review physician shall be available to discuss
21 the medical necessity of the urgent health care services with
22 the subscriber's health care practitioner or the subscriber's
23 designee.

24 Section 9. Utilization review entity duties concerning
25 emergency health care services.

26 (a) A utilization review entity cannot require
27 preauthorization.--No utilization review entity may require
28 preauthorization for prehospital transportation or treatment for
29 emergency health care services, including postevaluation and
30 poststabilization services.

1 (b) Restrictions concerning time limits within which
2 notification of inpatient admissions may be required.--A
3 utilization review entity shall allow a subscriber and the
4 subscriber's health care practitioner a minimum of one business
5 day following an emergency admission, service or procedure to
6 notify the utilization review entity of the admission, service
7 or procedure.

8 Section 10. Notifications of adverse determinations.

9 Written notice of adverse determinations shall be provided to
10 the subscriber and the subscriber's health care practitioner
11 which shall include instructions concerning how an appeal may be
12 performed.

13 Section 11. Reviews of appeals.

14 (a) Expedited appeals.--

15 (1) A subscriber or the subscriber's health care
16 practitioner may request an expedited appeal of an adverse
17 determination via telephone, facsimile, electronic mail or
18 other expeditious method.

19 (2) Within one business day of receiving an expedited
20 appeal and all information necessary to decide the appeal,
21 the utilization review entity shall provide the subscriber
22 and the subscriber's health care practitioner written
23 confirmation of the expedited review determination.

24 (b) Physicians to review appeals.--An appeal shall be
25 reviewed only by a physician who is:

26 (1) Board certified in the same specialty as a health
27 care practitioner who typically manages the medical condition
28 or disease.

29 (2) Currently in active practice in the same specialty
30 as the health care practitioner who typically manages the

1 medical condition or disease.

2 (3) Knowledgeable of and has experience providing the
3 health care services under appeal.

4 (4) Not employed by a utilization review entity, under
5 contract with the utilization review entity, other than to
6 participate in one or more of the utilization review entity's
7 health care provider networks or to perform reviews of
8 appeals, or otherwise have any financial interest in the
9 outcome of the appeal.

10 (5) Not involved in making the adverse determination.

11 (6) Familiar with all known clinical aspects of the
12 health care services under review, including, but not limited
13 to, all pertinent medical records provided to the
14 utilization review entity by the subscriber's health care
15 practitioner and any relevant records provided to the
16 utilization review entity by a health care facility.

17 (c) Procedures.--The utilization review entity shall ensure
18 that appeal procedures satisfy the following requirements:

19 (1) (i) The subscriber and the subscriber's health care
20 practitioner may challenge the adverse determination and
21 have the right to appear in person before the physician
22 who reviews the adverse determination.

23 (ii) The utilization review entity shall provide the
24 subscriber and the subscriber's health care practitioner
25 with written notice of the time and place concerning
26 where the review meeting will take place. Notice shall be
27 given to the subscriber's health care practitioner at
28 least 15 business days in advance of the review meeting.

29 (iii) If the subscriber or health care practitioner
30 cannot appear in person, the utilization review entity

1 shall offer the subscriber or health care practitioner
2 the opportunity to communicate with the reviewing
3 physician, at the utilization review entity's expense, by
4 conference call, video conferencing or other available
5 technology.

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

11 (d) Deadlines.--

12 (1) A utilization review entity shall decide an
13 expedited appeal and notify the subscriber and health care
14 practitioner of the determination within one business day
15 after receiving a notice of expedited appeal by the
16 subscriber and health care practitioner and all information
17 necessary to decide the appeal.

18 (2) A utilization review entity shall issue a written
19 determination concerning a nonexpedited appeal not later than
20 20 days after receiving a notice of appeal from a subscriber
21 or health care practitioner and all information necessary to
22 decide the appeal.

23 (e) Notifications of final adverse determinations.--Written
24 notice of final adverse determinations shall be provided to the
25 subscriber and the subscriber's health care practitioner.

26 Section 12. Continuation of coverage pending conclusion of the
27 appeal procedure.

28 If the appeal of an adverse determination concerns ongoing
29 health care services that are being provided pursuant to an
30 initially authorized admission or course of treatment, the

1 health care services shall be continued without liability to the
2 subscriber or the subscriber's health care practitioner until:

3 (1) The subscriber and the subscriber's health care
4 practitioner received a notice of final adverse determination
5 satisfying the requirements of a determination under section
6 (11) (e).

7 (2) The subscriber and the subscriber's health care
8 practitioner receive notice of a decision reached by an
9 external review concerning the medical necessity of the
10 health care services that were the subject of the final
11 adverse determination, if the subscriber or the subscriber's
12 health care practitioner appeals a final adverse
13 determination to an external review proceeding.

14 Section 13. Limitation on requests for medical records.

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

21 Section 14. Preauthorization by secondary payers.

22 In the event that a subscriber is covered by more than one
23 health plan that requires preauthorization, the following
24 provisions shall apply:

25 (1) The primary health plan may require the subscriber
26 to comply with the primary health plan's preauthorization
27 requirements.

28 (2) If the secondary payer also requires
29 preauthorization of the health care services, the secondary
30 payer may not refuse payment for those health care services

1 solely on the basis that the secondary payer did not
2 preauthorize the health care services.

3 Section 15. No cost to the subscriber or the subscriber's
4 health care practitioner.

5 An appeal of an adverse determination or external review of a
6 final adverse determination shall be provided without charge to
7 the subscriber or health care practitioner.

8 Section 16. Effect of noncompliance.

9 Failure by a utilization review entity to comply with the
10 deadlines and other requirements specified in this act shall
11 result in health care services subject to review to be deemed
12 preauthorized.

13 Section 17. Uniform preauthorization form.

14 (a) Panel to be convened.--Within three months of the
15 effective date of this section, the Insurance Department shall
16 convene a panel. The panel shall develop a uniform
17 preauthorization form that all health care practitioners in this
18 Commonwealth shall use to request preauthorization and that all
19 health insurers shall accept as sufficient to request
20 preauthorization of health care services.

21 (b) Membership of panel.--The panel shall consist of not
22 fewer than 10 persons. Equal representation shall be afforded to
23 the physician, health care facility, employer, health insurer
24 and consumer protection communities within this Commonwealth.

25 (c) Development of form.--Within one year of the effective
26 date of this section, the panel shall conclude development of
27 the uniform preauthorization form and the Insurance Department
28 shall make the uniform preauthorization form available to health
29 care practitioners in this Commonwealth and utilization review
30 agents.

1 Section 18. Exemption.

2 (a) Preauthorization.--When appropriate use criteria exists
3 for a particular health care service, the health care service
4 shall be exempt from preauthorization if the provision of the
5 health care service comports with applicable appropriate use
6 criteria.

7 (b) Retrospective review.--A health care service that has
8 been provided in accordance with applicable appropriate use
9 criteria shall not be subject to retrospective review.

10 Section 19. Effective date.

11 This act shall take effect in 60 days.