

AMENDMENTS TO SENATE BILL NO. 225

Sponsor: SENATOR PHILLIPS-HILL

Printer's No. 453

1 Amend Bill, page 1, lines 1 through 22, by striking out all
2 of said lines and inserting

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

24 Amend Bill, page 1, lines 25 through 27; pages 2 through 32,
25 lines 1 through 30; page 33, lines 1 through 23; by striking out
26 all of said lines on said pages and inserting

27 Section 1. The definitions of "emergency service,"
28 "grievance," "health care service," "prospective utilization
29 review," "retrospective utilization review," "utilization
30 review" and "utilization review entity" in section 2102 of the
31 act of May 17, 1921 (P.L.682, No.284), known as The Insurance
32 Company Law of 1921, are amended and the section is amended by
33 adding definitions to read:

34 Section 2102. Definitions.--As used in this article, the
35 following words and phrases shall have the meanings given to

1 them in this section:

2 * * *

3 "Administrative defect." Any deficiency, error, mistake or
4 missing information other than medical necessity or an uncovered
5 benefit that serves as the basis of an adverse determination
6 issued by a utilization review entity as justification to deny
7 prior utilization review or preauthorization.

8 "Adverse determination." The following shall apply:

9 (1) A decision made by a utilization review entity following
10 a preauthorization request that denies coverage for one or more
11 the following reasons:

12 (i) The health care service requested through
13 preauthorization are not medically necessary.

14 (ii) The preauthorization or prior utilization review
15 request contains an administrative defect.

16 (iii) The health care services requested through
17 preauthorization are subject to the benefit coverage of a
18 managed care plan that has been denied, modified or terminated
19 either prior to the request for preauthorization or as a result
20 of the requested preauthorization.

21 (2) The term includes a decision to deny a step therapy
22 exception request under section 2118.

23 (3) The term does not include a decision to deny, reduce or
24 terminate services that are not covered for reasons other than
25 medical necessity, experimental or investigational nature.

26 * * *

27 "Authorization." A determination by a managed care plan or
28 utilization review entity that:

29 (1) A health care service has been reviewed and, based on
30 the information provided, is medically necessary.

31 (2) The health care service reviewed is a covered service
32 under the plan.

33 (3) Payment will be made for the health care service subject
34 to copay, deductible and health care network restrictions.

35 * * *

36 "Clinical criteria." Policies, screening procedures,
37 determination rules, determination abstracts, clinical
38 protocols, practice guidelines and medical protocols that are
39 specified in a written document available for peer-to-peer
40 review by a peer within the same profession and specialty and
41 subject to challenge by an enrollee, a provider or a provider
42 organization when used as a basis to withhold preauthorization,
43 deny or otherwise modify coverage and that is used by a
44 utilization review entity to determine the medical necessity of
45 health care services. The criteria shall:

46 (1) Be based on nationally recognized standards.

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

49 (3) Reflect community standards of care.

50 (4) Ensure quality of care and access to needed health care
51 services.

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

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

5 (7) Be evaluated and updated annually.

6 * * *

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

15 (1) placing the health of the enrollee or, with respect to a
16 pregnant woman, the health of the woman or her unborn child in
17 serious jeopardy;

18 (2) serious impairment to bodily functions; or

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

20 Emergency transportation and related emergency service provided
21 by a licensed ambulance service shall constitute an emergency
22 service.

23 * * *

24 "Final adverse determination." An adverse determination that
25 has been upheld by a utilization review entity or managed care
26 plan at the completion of the internal grievance process.

27 "Grievance." As provided in subdivision (i), a request by an
28 enrollee or a health care provider, with the written consent of
29 the enrollee, to have a managed care plan or utilization review
30 entity reconsider a decision solely concerning the medical
31 necessity [and appropriateness] of a health care service. If the
32 managed care plan is unable to resolve the matter, a grievance
33 may be filed regarding the decision that:

34 (1) disapproves full or partial payment for a requested
35 health care service;

36 (2) approves the provision of a requested health care
37 service for a lesser scope or duration than requested; or

38 (3) disapproves payment for the provision of a requested
39 health care service but approves payment for the provision of an
40 alternative health care service.

41 The term does not include a complaint.

42 * * *

43 "Health care service." Any [covered] treatment, admission,
44 procedure, test used to aid in diagnosis or the provisions of
45 the applicable treatment, pharmaceutical product, medical
46 supplies and equipment or other services, including behavioral
47 health[, prescribed or otherwise] provided or proposed to be
48 provided by a health care provider to an enrollee under a
49 managed care plan contract.

50 * * *

51 "Medically necessary health care services" or "medically

1 necessary." Health care services that a prudent health care
2 provider would provide to a patient for the purpose of
3 preventing, diagnosing or treating an illness, injury, disease
4 or its symptoms in a manner that meets all the following:

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 in accordance with clinical criteria.

9 "Nonurgent health care service." A health care service
10 provided to an enrollee that is not considered an emergency
11 service or an urgent health care service.

12 * * *

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

19 * * *

20 "Retrospective utilization review[.]" or "retrospective
21 review." A review by a utilization review entity of all
22 reasonably necessary supporting information which occurs
23 following delivery or provision of a health care service and
24 results in a decision to approve or deny payment for the health
25 care service.

26 * * *

27 "Urgent health care service." The following shall apply:

28 (1) A health care service deemed by a provider to require
29 expedited preauthorization review in the event a delay may
30 jeopardize life or health of the enrollee or a delay in
31 treatment could do any of the following:

32 (i) Negatively affect the ability of the enrollee to regain
33 maximum function.

34 (ii) Subject the enrollee to severe pain that cannot be
35 adequately managed without receiving the care or treatment that
36 is the subject of the utilization review as quickly as possible.

37 (2) The term does not include an emergency service or
38 nonurgent health care service.

39 "Utilization review." A system of prospective, concurrent or
40 retrospective utilization review performed by a utilization
41 review entity of the medical necessity [and appropriateness] of
42 health care services prescribed, provided or proposed to be
43 provided to an enrollee. The term does not include any of the
44 following:

45 (1) Requests for clarification of coverage, eligibility or
46 health care service verification.

47 (2) A health care provider's internal quality assurance or
48 utilization review process unless the review results in denial
49 of payment for a health care service.

50 "Utilization review entity." Any entity certified pursuant
51 to subdivision (h) that performs utilization review on behalf of

1 a managed care plan. The term includes all the following:
2 (1) An insurer that writes health insurance policies,
3 including preferred provider organizations as defined in section
4 630.

5 (2) Pharmacy benefits managers responsible for managing
6 access of enrollees to available pharmaceutical or
7 pharmacological care.

8 (3) A health insurer if the health insurer performs
9 utilization review.

10 Section 2. Section 2111(3) of the act is amended and the
11 section is amended by adding paragraphs to read:

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

14 * * *

15 (3) [Adopt and maintain a definition of medical necessity
16 used by the plan in determining health care services.]

17 Establish an electronic platform and process for the submission
18 and receipt of prior authorization requests by network
19 providers. The following shall apply:

20 (i) Each managed care plan must provide written instructions
21 and training to network providers who may submit requests using
22 the electronic platform that set forth protocols addressing
23 submission of preauthorization requests if any of the following
24 apply:

25 (A) The electronic platform is not available due to
26 technological failure or electronic failure.

27 (B) Documents requested by the managed care plan or
28 utilization review entity exceed the submission capacity
29 limitations of the electronic platform.

30 (ii) Each managed health care plan shall establish mutually
31 agreeable terms for submission of preauthorization requests and
32 communication regarding preauthorization in circumstances where
33 a network provider or health care facility does not have either
34 of the following:

35 (A) Internet access.

36 (B) An electronic health record systems.

37 * * *

38 (14) Publish available health care services subject to prior
39 authorization on its publicly accessible Internet website in an
40 easily accessible manner and shall provide the information upon
41 request of a participating network provider.

42 (15) Provide sixty (60) days notice to participating network
43 providers of any changes to existing prior authorization
44 criteria or implementation of new prior authorization
45 requirements.

46 (16) Establish a protocol to obtain an exception from any
47 step therapy requirements and publish that process in an easily
48 accessible manner on its publicly accessible Internet website.

49 (17) Provide the rules and criteria related to the step
50 therapy protocol upon request to all prescribing network
51 providers.

1 Section 3. The act is amended by adding sections to read:
2 Section 2114. Preauthorization Review Standards.--(a)
3 Preauthorization approval requests may be submitted
4 electronically through a secure electronic transmission platform
5 established and maintained by a managed care plan under section
6 2111(3). An electronic submission shall not be required in
7 circumstances where the managed care plan has not published
8 protocols or provided training as required by section 2111(3).

9 (b) Any restriction that a utilization review entity places
10 on the preauthorization of health care services shall be in
11 accordance with the following:

12 (1) Based on the medical necessity of those services and on
13 any additional clinical criteria information submitted by the
14 provider seeking authorization of the health care service on
15 behalf of the enrollee.

16 (2) Applied consistently.

17 (3) Disclosed by the managed care plan or utilization review
18 entity under sections 2111 and 2136.

19 (c) Adverse determinations and final adverse determinations
20 made by a utilization review entity or agent thereof shall be
21 based on medical necessity and supporting clinical criteria
22 submitted by the provider seeking authorization for the health
23 care service on behalf of the enrollee.

24 (d) A utilization review entity shall not deny coverage of a
25 health care service solely based on the grounds that the health
26 care service does not meet clinical criteria.

27 (e) Preauthorization shall not be required in any of the
28 following:

29 (1) If a prescribed medication is a noncontrolled generic
30 medication.

31 (2) If a procedure to be performed is customary and properly
32 indicated or is a treatment for the clinical indication as
33 supported by peer-reviewed medical publications.

34 (3) For the provision of MAT for the treatment of an opioid-
35 use disorder.

36 (f) If a provider contacts a utilization review entity
37 seeking preauthorization for a medically necessary health care
38 service under section 2111(14) and the utilization review
39 entity, through an agent, contractor, employe or representative
40 informs the provider that preauthorization is not required for
41 the health care service subject to the request, coverage for the
42 service shall be deemed approved.

43 Section 2115. Preauthorization Costs.--(a) In the event
44 that an insured is covered by more than one health plan that
45 requires preauthorization:

46 (1) A secondary managed health care plan shall not deny
47 preauthorization for a health care service solely on the basis
48 that the preauthorization procedures of the secondary insurer
49 were not followed if the enrollee subject to the plan received
50 preauthorization from the enrollee's primary managed health care
51 plan.

1 (2) Nothing in this section shall be construed to preclude a
2 secondary insurer from requiring preauthorization for a health
3 care service denied preauthorization by a primary insurer.

4 (b) Any internal grievance or internal review of an adverse
5 determination of a final adverse determination shall be provided
6 without charge to the enrollee or enrollee's health care
7 provider.

8 Section 4. Section 2117 of the act is amended by adding
9 subsections to read:

10 Section 2117. Continuity of Care.--* * *

11 (g) If the appeal of an adverse determination from a
12 preauthorization request concerns ongoing health care services
13 provided under an initially authorized admission or course of
14 treatment, the health care services shall continue to be
15 provided to the enrollee and paid for by the managed care plan
16 without liability to the enrollee or the enrollee's health care
17 provider for no less than sixty (60) days.

18 (h) The managed care plan or utilization review entity shall
19 not be permitted to retroactively review the decision to
20 authorize and provide health care services through
21 preauthorization, including preauthorization for extending the
22 term or course of treatment unless the managed care plan or
23 utilization review entity can demonstrate by clear and
24 convincing evidence that preauthorization was authorized using
25 knowingly inaccurate clinical information submitted by the
26 provider or fraud.

27 (i) Notwithstanding any other provision of law, the managed
28 care plan shall not retroactively recover the cost of treatment
29 either for the initial period of treatment subject to
30 preauthorization or the period of treatment provided to the
31 enrollee as part of the preauthorization decision-making process
32 to authorize coverage of additional treatment periods.

33 (j) Continued care shall not be subject to concurrent review
34 if the treatment regimen or continuity of care follows from a
35 authorizing previous preauthorization request unless the managed
36 care plan or utilization review entity can demonstrate by clear
37 and convincing evidence that preauthorization was authorized
38 using knowingly inaccurate clinical information submitted by the
39 provider or fraud.

40 Section 5. The act is amended by adding a section to read:

41 Section 2118. Step Therapy.--(a) (1) When coverage of a
42 prescription drug for the treatment of any medical condition is
43 restricted for use by a managed care plan or utilization review
44 entity through a step therapy protocol, the enrollee and
45 provider shall have access to a clear, readily accessible and
46 convenient process to request a step therapy exception under
47 section 2111(16). Failure of the managed care plan to meet its
48 obligation under section 2111 shall result in all step therapy
49 exceptions being deemed approved until the managed care plan
50 complies with the requirements of section 2111(16).

51 (2) No step therapy shall be required if the medication

1 being prescribed is being prescribed in response to an
2 emergency.

3 (3) A step therapy exception shall be granted if any of the
4 following apply:

5 (i) The required prescription drug is contraindicated, not
6 in the best interest of the enrollee or will likely cause an
7 adverse reaction by or physical or mental harm to the enrollee.

8 (ii) The required prescription drug is expected to be
9 ineffective based on the known clinical characteristics of the
10 enrollee and the known characteristics of the prescription drug
11 regimen.

12 (iii) The enrollee has tried the required prescription drug
13 while under the enrollee's current or previous health care plan
14 or health benefit plan, or another prescription drug in the same
15 pharmacologic class or with the same mechanism of action, and
16 the prescription drug was discontinued due to lack of efficacy
17 or effectiveness, diminished effect or an adverse event.

18 (iv) The enrollee is stable on a prescription drug
19 previously selected by the enrollee's provider and previously
20 approved by a managed care plan or utilization review entity.

21 (4) Granting the step therapy exception shall authorize
22 coverage for the prescription drug prescribed by the enrollee's
23 treating health care provider.

24 (b) Step therapy exception requests or an appeal thereof
25 shall be granted or denied within five (5) business days of
26 receipt, subject to the following:

27 (1) In cases where the requested exception is related to an
28 urgent healthcare treatment, the managed care plan or
29 utilization review entity evaluating the exception shall respond
30 within twenty-four (24) hours of receipt of the request.

31 (2) If a request for an exception under this section is
32 incomplete or additional clinically relevant information is
33 required, the managed care plan or utilization review entity
34 shall notify the prescribing practitioner within five (5)
35 business days of submission, or twenty-four (24) hours in an
36 urgent health care request, that additional or clinically
37 relevant information is required in order to approve or deny the
38 step therapy exception request or appeal under this section. The
39 request for additional information may only extend the deadlines
40 herein an additional forty-eight (48) hours for nonurgent
41 healthcare services subject to step therapy.

42 (c) If a determination is not rendered within the applicable
43 deadlines, the requested exception shall be deemed approved, and
44 treatment authorized. In a circumstance where the exception has
45 been deemed approved and treatment has been authorized shall not
46 be subject to concurrent review or retroactive review because of
47 the failure of the managed care plan to render a determination
48 under this section.

49 (d) In the event of a denial, the managed care plan or
50 utilization review entity shall inform the enrollee of the right
51 to a grievance process. This subsection shall not be construed

1 to prevent:

2 (1) A managed care plan or utilization review entity from
3 requiring a pharmacist to effect substitutions of prescription
4 drugs consistent with the laws of this Commonwealth.

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

7 (e) As used in this section, the following words and phrases
8 shall have the meanings given to them in this section:

9 "Step therapy exception." When a step therapy protocol should
10 be overridden in favor of immediate coverage of the health care
11 provider's selected prescription drug.

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

16 Section 6. Article XXI, Subdivision (f) heading of the act
17 is amended to read:

18 (f) Information for Enrollees and Health Care Providers.

19 Section 7. Section 2136 of the act is amended by adding a
20 subsection to read:

21 Section 2136. Required Disclosure.--* * *

22 (c) If either a managed care plan or utilization review
23 entity intends to implement a new preauthorization requirement
24 or restriction or amend an existing requirement or restriction,
25 the managed care plan or utilization review entity shall provide
26 network providers and enrollees with written notice of the new
27 or amended requirement or amendment not less than sixty (60)
28 days before implementation. The notice shall be in writing which
29 may be satisfied by any of the following:

30 (1) Mail through the United States Postal Service.

31 (2) Electronic mail read receipt requested.

32 (3) Publication on the publicly accessible Internet website
33 of the managed care plan or utilization review entity with an
34 electronic mail message to network providers and enrollees that
35 identifies the location of the publication on the website.

36 (4) Web-exchange, provided that an electronic mail message
37 on how to access the web-exchange is sent to network providers
38 and enrollees.

39 (5) Any other contractually agreed upon method, specifying
40 the details of the communication which include some proof of
41 receipt by the network providers and enrollees.

42 Section 8. Section 2152(a)(4) and (6) of the act are
43 amended, subsection (a) is amended by adding paragraphs and the
44 section is amended by adding a subsection to read:

45 Section 2152. Operational Standards.--(a) A utilization
46 review entity shall do all of the following:

47 * * *

48 (4) Conduct utilization reviews based on the medical
49 necessity [and appropriateness] of the health care service being
50 reviewed and provide notification within the following time
51 frames:

1 (i) [A prospective utilization review decision shall be
2 communicated within two (2) business days of the receipt of all
3 supporting information reasonably necessary to complete the
4 review.] A prospective utilization review or preauthorization
5 decision shall be rendered not more than seven (7) days after
6 initial submission of the request for authorization. The
7 decision to authorize or deny the requested health care service
8 shall be communicated within five (5) business days of the
9 receipt of all supporting information reasonably necessary to
10 complete the review. If the initial submission does not contain
11 all of the supporting information reasonably necessary to
12 complete the review, the utilization review entity may request
13 additional information from the provider but the request shall
14 only extend the seven (7) day deadline for a decision either
15 authorizing or denying the health care service an additional
16 forty-eight (48) hours.

17 (ii) A concurrent utilization review decision shall be
18 communicated within one (1) business day of the receipt of all
19 supporting information reasonably necessary to complete the
20 review.

21 (iii) A retrospective utilization review decision shall be
22 communicated within thirty (30) days of the receipt of all
23 supporting information reasonably necessary to complete the
24 review. Utilization review entities shall not retroactively
25 review the medical necessity of a preauthorization that has been
26 previously approved or granted under section 2117.

27 (iv) A utilization review entity shall allow an enrollee and
28 the enrollee's health care provider a minimum of one (1)
29 business day following an inpatient admission under emergency
30 health care service or urgent health care service to notify the
31 utilization review entity of the admission and any health care
32 services performed.

33 * * *

34 (6) Provide all decisions in writing to include the basis
35 and clinical rationale for the decision. For adverse
36 determinations from preauthorization requests, a utilization
37 review entity shall provide notice of all adverse determinations
38 to the enrollee and the enrollee's health care provider. The
39 notice of adverse determination shall include instructions
40 concerning how a grievance may be filed for an adverse
41 determination based on medical necessity. If the adverse
42 determination is based on an administrative defect, the
43 determination shall provide information on how the defect may be
44 cured and instructions for resubmitting the preauthorization
45 request.

46 * * *

47 (9) Post the following to the utilization review entity's
48 publicly accessible Internet website:

49 (i) A current list of services and supplies requiring
50 preauthorization.

51 (ii) Written clinical criteria for preauthorization

1 decisions.

2 (10) Ensure that a preauthorization shall be valid for no
3 longer than one hundred eighty (180) days or the duration of
4 treatment, whichever is greater, from the date the health care
5 provider receives the preauthorization so long as the enrollee
6 is a member of the plan.

7 (11) When performing preauthorization, only request copies
8 of medical records relevant to determining the medical necessity
9 of a health care service requested.

10 (12) In the event an administrative defect is discovered, a
11 managed care plan shall allow a health care provider the
12 opportunity to remedy the administrative defect within forty-
13 eight hours (48) hours of receiving notice of the defect. If a
14 health care provider remedies the administrative defect, a
15 determination of preauthorization shall be rendered within
16 forty-eight (48) hours. If the administrative defect remains
17 uncured, the managed care plan may deny preauthorization.

18 * * *

19 (e) Failure by a utilization review entity to comply with
20 deadlines and other requirements specified for preauthorization
21 shall result in the requested preauthorization for the health
22 care service to be deemed authorized and paid by the managed
23 care plan. Failure of the provider cure any administrative
24 defects in preauthorization requests in a timely manner under
25 this section may result in the preauthorization being denied.

26 Section 9. The act is amended by adding sections to read:

27 Section 2161.1. Initial Review of Preauthorization Requests
28 and Adverse Determinations.--(a) A utilization review entity
29 shall ensure that:

30 (1) A denial based on the medical necessity of a
31 preauthorization request is made by a qualified licensed health
32 care provider who has knowledge of the items, services,
33 products, tests or procedures submitted for preauthorization.

34 (2) If an adverse determination is made by a physician and
35 based on medical necessity, then the physician must possess a
36 current and valid nonrestricted license to practice medicine in
37 this Commonwealth and be board certified. If the
38 preauthorization review requires a peer-to-peer review in the
39 specialty or subspecialty where a review is requested by the
40 submitting provider, then the physician conducting the review on
41 behalf of the utilization review entity shall be of a similar
42 specialty to the health care service for which preauthorization
43 is requested.

44 (b) Notification of a preauthorization shall be accompanied
45 by a unique preauthorization number and indicate:

46 (1) The specific health care services preauthorized.

47 (2) The next date for review.

48 (3) The date of admission or initiation of services, if
49 applicable.

50 (c) In the event a health care provider obtains
51 preauthorization for one (1) service but the service provided is

1 not an exact match to the service that was preauthorized a
2 utilization review entity or managed care plan shall grant
3 authorization for the health care service provided and remit
4 payment at a rate of reimbursement that is associated with
5 either the preauthorized health care service or the service
6 appropriately substituted based on common procedural terminology
7 and clinical criteria.

8 (d) (1) If a utilization review entity challenges the
9 medical necessity of a health care service, the utilization
10 review entity shall notify the enrollee's health care provider
11 that medical necessity is being challenged and provide the basis
12 of the challenge in sufficient detail to allow the provider
13 requesting authorization of the health care service to
14 meaningfully address the challenge raised by the utilization
15 review entity prior to issuing an adverse determination.

16 (2) The enrollee's health care provider or designee and the
17 enrollee or enrollee's designee shall have the right to discuss
18 the medical necessity of the health care service with the
19 utilization review physician.

20 (3) A utilization review entity questioning medical
21 necessity of a health care service which may result in an
22 adverse determination shall ensure a reviewing physician making
23 the decision is available telephonically at a specifically
24 appointed mutually agreeable time scheduled in advance between
25 the provider requesting the health care service and reviewing
26 physician between the hours of seven (7) o'clock antemeridian
27 and seven (7) o'clock postmeridian. If the utilization review
28 entity fails to make the reviewing physician available as
29 required by this paragraph, the health care service subject to
30 the preauthorization request shall be deemed authorized.

31 (e) When making a determination based on medical necessity,
32 a utilization review entity shall base the determination on an
33 enrollee's presenting symptoms, diagnosis and information
34 available through the course of treatment or at the time of
35 admission. Such information may also include any medical
36 information collected at the time the enrollee presented to the
37 emergency department if the information is relevant to the
38 determination.

39 (f) In the event a utilization review entity determines an
40 alternative level of care is appropriate, the utilization review
41 entity shall provide notice of the alternative level of care to
42 the provider requesting preauthorization for a health care
43 service and cite the specific criteria used as the basis for the
44 alternative level of care determination to the health care
45 provider prior to denying preauthorization. An alternative level
46 of care decision shall be subject to a peer-to-peer review as
47 under this section.

48 (g) A utilization review entity may not issue an adverse
49 determination for a procedure due to lack of preauthorization if
50 the procedure is medically necessary or clinically appropriate
51 for the patient's medical condition and rendered at the same

1 time as a related procedure for which preauthorization was
2 required and received.

3 (h) A utilization review entity shall make a
4 preauthorization adverse determination decision and notify the
5 enrollee and the enrollee's health care provider as follows:

6 (1) For nonurgent health care services, within five (5) days
7 of obtaining all the necessary information to make the
8 preauthorization or adverse determination, so long as the entire
9 review process is completed either seven (7) days following the
10 initial request if no additional information is requested by the
11 utilization review entity or nine (9) days following the initial
12 submission if additional information is requested.

13 (2) For urgent health care services, within forty-eight (48)
14 hours from submission of the request for prior authorization. No
15 utilization review entity may require preauthorization for an
16 emergency service, including post evaluation and
17 poststabilization services.

18 Section 2161.2. Preauthorization Denial Grievances.--(a) An
19 enrollee or the enrollee's health care provider may submit a
20 grievance and request an expedited review of an adverse
21 determination via telephone, facsimile, electronic mail or other
22 method. Within one (1) day of receiving an expedited request and
23 all information necessary to make a determination, the
24 utilization review entity shall provide the enrollee and the
25 enrollee's health care provider written confirmation of the
26 expedited review determination.

27 (b) A grievance shall be reviewed only by a physician who
28 satisfies any of the following conditions:

29 (1) Is board certified in the same specialty as a health
30 care practitioner who typically manages the medical condition or
31 disease.

32 (2) Is currently in active practice, provided that in events
33 where circumstances justify it or where the provider seeking
34 preauthorization specifically requests a health care provider
35 actively engaged in the specialty who typically manages the
36 medical condition or disease, the physician shall be made
37 available for the review.

38 (3) Is knowledgeable of, and has experience in, providing
39 the health care services under grievance.

40 (4) Is under contract with a utilization review entity to
41 perform reviews of grievances and payment of fees due under the
42 contract, but the performance and payment is not subject to or
43 contingent upon the outcome of the appeal. The following shall
44 apply:

45 (i) The physician may also be subject to a provider
46 agreement with the managed care plan as a network provider, but
47 shall not receive any other fee or compensation from the managed
48 care plan.

49 (ii) The physician's receipt of compensation from either the
50 managed care plan or the utilization review entity shall not be
51 considered by the physician in determining the conclusion

1 reached by the physician.

2 (iii) The physician shall at all times render independent
3 and accurate medical judgment in reaching an opinion or
4 conclusion.

5 (iv) Failure to comply with this provision shall render the
6 physician subject to licensure disciplinary action by the
7 appropriate licensing board.

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

9 (6) Familiar with all known clinical aspects of the health
10 care services under review, including all pertinent medical
11 records provided to the utilization review entity by the
12 enrollee's health care provider and any relevant record provided
13 to the utilization review entity by a health care facility.

14 (c) The utilization review entity shall ensure that
15 grievance review procedures satisfy the following requirements:

16 (1) The enrollee and the enrollee's health care provider may
17 challenge the adverse determination and have the right to appear
18 in person before the utilization review entity, including the
19 reviewing physician, who reviews the adverse determination.

20 (2) The utilization review entity shall provide the enrollee
21 and the enrollee's health care provider written notice of the
22 time and place concerning where the review meeting will take
23 place. Notice shall be given to the enrollee's health care
24 provider at least fourteen (14) days in advance of the review
25 meeting.

26 (3) If the enrollee or the enrollee's health care provider
27 appear in person, the utilization review entity shall offer the
28 enrollee or enrollee's health care provider the opportunity to
29 communicate with the reviewing physician, at the utilization
30 review entity's expense, by conference call, video conferencing
31 or other available technology.

32 (4) The physician performing the review of the grievance
33 shall consider all information, documentation or other material
34 submitted in connection with the grievance without regard to
35 whether the information was considered in making the adverse
36 determination.

37 (d) The following deadlines shall apply to the utilization
38 review entities:

39 (1) A utilization review entity shall decide a grievance
40 submitted for expedited review and notify the enrollee and the
41 enrollee's health care provider of the determination within two

42 (2) days after receiving a notice of the expedited review
43 request by the enrollee or the enrollee's health care provider
44 and all information necessary to render a decision.

45 (2) A utilization review entity shall issue a written
46 determination concerning a nonexpedited grievance not later than
47 thirty (30) days after receiving a notice of the grievance from
48 an enrollee or enrollee's health care provider.

49 (e) Written notice of final an adverse determination shall
50 be provided to the enrollee and the enrollee's health care
51 provider.

1 (f) If the enrollee or the enrollee's health care provider
2 or a designee on behalf of either the enrollee or the enrollee's
3 health care provider has satisfied all necessary requirements
4 for the grievance review determination of an adverse
5 determination through the preauthorization process and the
6 determination has resulted in a continued adverse determination
7 either based on lack of medical necessity or an administrative
8 defect, the enrollee, the enrollee's health care provider or a
9 designee on behalf of either the enrollee or the enrollee's
10 health care provider or a designee may file a consumer complaint
11 with the Department of Health if for continued lack of medical
12 necessity and the Insurance Department if for administrative
13 defect. The complaint shall be adjudicated without unnecessary
14 delay in accordance with current law and a determination issued
15 by the relevant department with appropriate sanctions, if
16 applicable, under the authority given to that department.

17 (g) To the extent that an enrollee, an enrollee's health
18 care provider or a designee on behalf of either the enrollee or
19 the enrollee's health care provider or a designee files a
20 consumer complaint with either department or the Office of
21 Attorney General under the authority to receive the complaints,
22 a copy of the complaint filed with either department or the
23 Office of Attorney General shall be forwarded to the Insurance
24 Department and the copy shall serve as a new consumer complaint
25 to be adjudicated under the terms of this section and all other
26 applicable law.

27 Section 2195. Access Requirements in Service Areas.--If an
28 enrollee's safe discharge is delayed for any reason, including
29 lack of available posthospitalization services, including
30 skilled nursing facilities, home health services and postacute
31 rehabilitation, the managed care plan shall reimburse the
32 hospital for each subsequent date of service at the greater of
33 the contracted rate with the managed care plan for the current
34 level of care and service or the full diagnostic related group
35 payment divided by the mean length of stay for the particular
36 diagnostic related group.

37 Section 11. Nothing in this act shall be construed to
38 preclude an insurer from developing a program exempting a health
39 care provider from preauthorization protocols.

40 Section 12. This act shall take effect in 60 days.