AMENDMENTS TO SENATE BILL NO. 225

Sponsor: SENATOR PHILLIPS-HILL

Printer's No. 453

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

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

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

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

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

them in this section:

* * *

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

"Adverse determination." The following shall apply:

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

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

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

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

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

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

* * *

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

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

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

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

* * *

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

(1) Be based on nationally recognized standards.

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

(3) Reflect community standards of care.

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

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

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

(7) Be evaluated and updated annually.

* * *

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

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

(2) serious impairment to bodily functions; or

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

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

* * *

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

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

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

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

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

The term does not include a complaint.

* * *

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

* * *

"Medically necessary health care services" or "medically

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

(1) In accordance with generally accepted standards of medical practice based on clinical criteria.

(2) Appropriate in terms of type, frequency, extent, site and duration in accordance with clinical criteria.

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

* * *

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

* * *

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

* * *

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

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

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

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

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

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

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

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

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

a managed care plan. The term includes all the following:

(1) An insurer that writes health insurance policies, including preferred provider organizations as defined in section 630.

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

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

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

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

* * *

(3) [Adopt and maintain a definition of medical necessity used by the plan in determining health care services.] Establish an electronic platform and process for the submission and receipt of prior authorization requests by network providers. The following shall apply:

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

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

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

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

(A) Internet access.

(B) An electronic health record systems.

* * *

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

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

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

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

Section 3. The act is amended by adding sections to read:

Section 2114. Preauthorization Review Standards.--(a) Preauthorization approval requests may be submitted electronically through a secure electronic transmission platform established and maintained by a managed care plan under section 2111(3). An electronic submission shall not be required in circumstances where the managed care plan has not published protocols or provided training as required by section 2111(3).

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

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

(2) Applied consistently.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

being prescribed is being prescribed in response to an emergency.

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

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

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

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

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

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

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

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

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

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

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

to prevent:

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

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

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

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

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

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

(f) Information for Enrollees and Health Care Providers.

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

Section 2136. Required Disclosure.--* * *

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

(1) Mail through the United States Postal Service.

(2) Electronic mail read receipt requested.

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

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

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

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

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

* * *

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

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

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

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

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

* * *

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

* * *

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

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

(ii) Written clinical criteria for preauthorization

decisions.

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

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

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

* * *

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

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

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

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

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

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

(1) The specific health care services preauthorized.

(2) The next date for review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reached by the physician.

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

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

(5) Not involved in making the adverse determination.

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

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

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

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

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

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

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

(1) A utilization review entity shall decide a grievance submitted for expedited review and notify the enrollee and the enrollee's health care provider of the determination within two (2) days after receiving a notice of the expedited review request by the enrollee or the enrollee's health care provider and all information necessary to render a decision.

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

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

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

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

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

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

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