

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 225 Session of
2021

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

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF
REPRESENTATIVES, AS AMENDED, SEPTEMBER 20, 2022

AN ACT

1 Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An
2 act relating to insurance; amending, revising, and
3 consolidating the law providing for the incorporation of
4 insurance companies, and the regulation, supervision, and
5 protection of home and foreign insurance companies, Lloyds
6 associations, reciprocal and inter-insurance exchanges, and
7 fire insurance rating bureaus, and the regulation and
8 supervision of insurance carried by such companies,
9 associations, and exchanges, including insurance carried by
10 the State Workmen's Insurance Fund; providing penalties; and
11 repealing existing laws," ~~in quality health care~~ <--
12 ~~accountability and protection, further providing for~~
13 ~~definitions, for responsibilities of managed care plans, for~~
14 ~~financial incentives prohibition, for medical gag clause~~
15 ~~prohibition, for emergency services, for continuity of care,~~
16 ~~providing for medication assisted treatment, further~~
17 ~~providing for procedures, for confidentiality, for required~~
18 ~~disclosure, providing for medical policy and clinical review~~
19 ~~criteria adopted by insurer, MCO or contractor, further~~
20 ~~providing for internal complaint process, for appeal of~~
21 ~~complaint, for complaint resolution, for certification, for~~
22 ~~operational standards, providing for step therapy~~
23 ~~considerations, for prior authorization review and for~~
24 ~~provider portal, further providing for internal grievances~~
25 ~~process, for records, for external grievance process, for~~
26 ~~prompt payment of claims, for health care provider and~~
27 ~~managed care plan, for departmental powers and duties, for~~
28 ~~penalties and sanctions, for compliance with National~~

1 ~~Accrediting Standards; and making editorial changes. IN~~ <--
2 QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION, FURTHER
3 PROVIDING FOR DEFINITIONS, FOR RESPONSIBILITIES OF MANAGED
4 CARE PLANS, FOR FINANCIAL INCENTIVES PROHIBITION, FOR MEDICAL
5 GAG CLAUSE PROHIBITION, FOR EMERGENCY SERVICES, FOR
6 CONTINUITY OF CARE, FOR PROCEDURES, FOR CONFIDENTIALITY, FOR
7 REQUIRED DISCLOSURE AND FOR INTERNAL COMPLAINT PROCESS,
8 PROVIDING FOR INTERNAL COMPLAINT PROCESS FOR ENROLLEES,
9 FURTHER PROVIDING FOR APPEAL OF COMPLAINT, FOR COMPLAINT
10 RESOLUTION, FOR CERTIFICATION AND FOR OPERATIONAL STANDARDS,
11 PROVIDING FOR UTILIZATION REVIEW STANDARDS, FURTHER PROVIDING
12 FOR INTERNAL GRIEVANCE PROCESS, FOR EXTERNAL GRIEVANCE
13 PROCESS AND FOR RECORDS, PROVIDING FOR ADVERSE BENEFIT
14 DETERMINATIONS, FURTHER PROVIDING FOR PROMPT PAYMENT OF
15 CLAIMS, FOR HEALTH CARE PROVIDER AND MANAGED CARE PLAN
16 PROTECTION, FOR DEPARTMENTAL POWERS AND DUTIES AND FOR
17 PENALTIES AND SANCTIONS, PROVIDING FOR REGULATIONS AND
18 FURTHER PROVIDING FOR COMPLIANCE WITH NATIONAL ACCREDITING
19 STANDARDS AND FOR EXCEPTIONS; MAKING REPEALS; AND MAKING
20 EDITORIAL CHANGES.

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

23 ~~Section 1. The definitions of "complaint," "drug formulary,"~~ <--
24 ~~"enrollee," "grievance," "health care service," "prospective~~
25 ~~utilization review," "provider network," "retrospective~~
26 ~~utilization review," "utilization review" and "utilization~~
27 ~~review entity" in section 2102 of the act of May 17, 1921~~
28 ~~(P.L.682, No.284), known as The Insurance Company Law of 1921,~~
29 ~~are amended and the section is amended by adding definitions to~~
30 ~~read:~~

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

34 ~~* * *~~

35 ~~"Administrative policy." A written document or collection of~~
36 ~~documents reflecting the terms of the contractual or operating~~
37 ~~relationship between an insurer, MCO, contractor and a health~~
38 ~~care provider.~~

39 ~~"Administrative denial." A denial of prior authorization,~~
40 ~~coverage or payment based on a lack of eligibility, failure to~~

~~submit complete information or other failure to comply with written administrative standards for the administration of benefits under a health insurance policy, MCO contract or CHIP contract. The term does not include a denial based on medical necessity.~~

~~"Adverse benefit determination." A determination by an insurer, MCO, contractor or a utilization review entity designated by the insurer, MCO or contractor that a health care service has been reviewed and, based upon the information provided, does not meet the insurer's, MCO's or contractor's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.~~

~~* * *~~

~~"Applicable governmental guidelines." Clinical practice and associated guidelines issued under the authority of the United States Department of Health and Human Services, United States Food and Drug Administration, Centers for Disease Control and Prevention, Department of Health or other similarly situated Federal or State agency, department or subunit thereof focused on the provision or regulation of medical care, prescription drugs or public health within the United States.~~

~~"Children's Health Insurance Program" or "CHIP." The children's health care program under Article XXIII-A.~~

~~"CHIP contract." The agreement between an insurer and the Department of Human Services to provide for services to a CHIP enrollee.~~

~~* * *~~

~~"Clinical review criteria." The set of written screening~~

~~procedures, decision abstracts, clinical protocols and practice guidelines used by an insurer, MCO or contractor to determine the necessity and appropriateness of health care services.~~

~~"Closely related service." One or more health care services subject to prior authorization that are closely related in purpose, diagnostic utility or designated health care billing code and provided on the same date of service such that a prudent health care provider, acting within the scope of the health care provider's license and expertise, might reasonably be expected to perform such service in conjunction with or in lieu of the originally authorized service in response to minor differences in observed patient characteristics or needs for diagnostic information that were not readily identifiable until the health care provider was actually performing the originally authorized service. The term does not include an order for or administration of a prescription drug or any part of a series or course of treatments.~~

~~"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of [a managed care plan] an insurer, MCO or contractor, which has not been resolved by the [managed care plan] insurer, MCO or contractor and has been filed with the [plan] insurer, MCO or contractor or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.~~

~~"Complete prior authorization request." A request for prior authorization that meets an insurer's, MCO's or contractor's administrative policy requirements for such a request and that includes the specific clinical information necessary only to evaluate the request under the terms of the applicable medical~~

~~policy. To the extent a health care provider network agreement requires medical records to be transmitted electronically, or a health care provider is capable of transmitting medical records electronically to support a complete prior authorization request for a health care service, the health care provider shall ensure the insurer, MCO or contractor has electronic access to, including the ability to print, the medical records that have been transmitted electronically, subject to any applicable law and the health care provider's corporate policies. The inability of a health care provider to provide such access shall not constitute a reason to deny an authorization request.~~

~~* * *~~

~~"Contractor." An insurer awarded a contract under section 2304 A to provide health care services. The term includes an entity and an entity's subsidiary which is established under this act, the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act or 40 Pa.C.S. Ch. 61 (relating to hospital plan corporation) or 63 (relating to professional health services plan corporations).~~

~~* * *~~

~~"Drug formulary." A listing of [managed care plan] insurer, MCO or contractor preferred therapeutic drugs.~~

~~* * *~~

~~"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a [managed care plan] health insurance policy, MCO contract or CHIP contract.~~

~~"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] an insurer, MCO,~~

~~contractor or utilization review entity reconsider a decision solely concerning the medical necessity [and], appropriateness, health care setting, level of care or effectiveness of a health care service. If the [managed care plan] insurer, MCO or contractor 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, 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.]~~

~~"Health insurance policy." A policy, subscriber contract, certificate or plan issued by an insurer that provides medical or health care coverage. The term does not include any of the following:~~

~~(1) An accident only policy.~~

~~(2) A credit only policy.~~

~~(3) A long term care or disability income policy.~~

~~(4) A specified disease policy.~~

~~(5) A Medicare supplement policy.~~

~~(6) A TRICARE policy, including a Civilian Health and~~

~~Medical Program of the Uniformed Services (CHAMPUS) supplement
policy.~~

~~(7) A fixed indemnity policy.~~

~~(8) A hospital indemnity policy.~~

~~(9) A dental only policy.~~

~~(10) A vision only policy.~~

~~(11) A workers' compensation policy.~~

~~(12) An automobile medical payment policy.~~

~~(13) A homeowners' insurance policy.~~

~~(14) A short term limited duration policy.~~

~~(15) Any other similar policy providing for limited
benefits.~~

~~"Inpatient admission." Admission to a facility for purposes
of receiving a health care service at the inpatient level of
care.~~

~~"Insurer." An entity licensed by the department to issue a
health insurance policy, subscriber contract, certificate or
plan that provides medical or health care coverage that is
offered or governed under any of the following:~~

~~(1) Article XXIV, section 630 or any other provision of this
act.~~

~~(2) A provision of 40 Pa.C.S. Ch. 61 or 63.~~

~~* * *~~

~~"MCO contract." The agreement between a medical assistance
managed care organization or MCO and the Department of Human
Services to provide for services to a Medicaid enrollee.~~

~~"Medical assistance managed care organization" or "MCO." A
Medicaid managed care organization as defined in section 1903(m)
(1) (A) of the Social Security Act (49 Stat. 620, 42 U.S.C. §
1396b(m) (1) (A)) that is a party to a Medicaid managed care~~

~~contract with the Department of Human Services. The term does not include a behavioral health managed care organization that is a party to a Medicaid managed care contract with the Department of Human Services.~~

~~"Medical policy." A written document formally adopted, maintained and applied by an insurer, MCO or contractor that combines the clinical coverage criteria and any additional administrative requirements, as applicable, necessary to articulate the insurer's, MCO's or contractor's standards for coverage of a given service or set of services under the terms of a health insurance policy, MCO contract or CHIP contract.~~

~~"Medical or scientific evidence." Evidence found in any of the following sources:~~

~~(1) A peer reviewed scientific study published in or accepted for publication by a medical journal that meets nationally recognized requirements for scientific manuscripts and which journal submits most of its published articles for review by experts who are not part of the journal's editorial staff.~~

~~(2) Peer reviewed medical literature, including literature relating to a therapy reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Limited for indexing in Excerpta Medica (EMBASE).~~

~~(3) A medical journal recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395x(t)(2)).~~

~~(4) One of the following standard reference compendia:~~

~~(i) The American Hospital Formulary Service Drug Information.~~

~~(ii) Drug Facts and Comparison.~~

~~(iii) The American Dental Association Accepted Dental Therapeutics.~~

~~(iv) The United States Pharmacopoeia Drug Information.~~

~~(5) Findings, studies or research conducted by or under the auspices of a Federal Government agency or nationally recognized Federal research institute, including:~~

~~(i) The Federal Agency for Healthcare Research and Quality.~~

~~(ii) The National Institute of Health.~~

~~(iii) The National Cancer Institute.~~

~~(iv) The National Academy of Sciences.~~

~~(v) The Centers for Medicare and Medicaid Services.~~

~~(vi) The Food and Drug Administration.~~

~~(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.~~

~~(6) Other medical or scientific evidence that is comparable to the sources specified in paragraphs (1), (2), (3), (4) and (5).~~

~~"Medication assisted treatment." United States Food and Drug Administration approved prescription drugs used in combination with counseling and behavioral health therapies in the treatment of opioid use disorders.~~

~~"Nationally recognized medical standards." Clinical criteria, practice guidelines and related standards established by national quality and accreditation entities generally recognized in the United States health care industry.~~

~~"Participating provider." A health care provider that has~~

~~entered into a contractual or operating relationship with an insurer, MCO or contractor to participate in one or more designated networks of the insurer, MCO or contractor and to provide health care services to enrollees under the terms of the insurer's, MCO's or contractor's administrative policy.~~

~~* * *~~

~~"Prior authorization." A review by an insurer, MCO, contractor or by a utilization review entity acting on behalf of an insurer, MCO or contractor 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. The term includes step therapy and associated exceptions for prescription drugs.~~

~~{"Prospective utilization review." 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.}~~

~~"Provider network." The health care providers designated by [a managed care plan] an insurer, MCO or contractor to provide health care services.~~

~~"Provider portal." A designated section or functional software module accessible via an insurer's, MCO's or contractor's publicly accessible Internet website that facilitates health care provider submission of electronic prior authorization requests.~~

~~* * *~~

~~"Retrospective utilization review." A review by [a] an insurer, MCO, contractor or utilization review entity acting on~~

~~behalf of an insurer, MCO or contractor 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.~~

~~* * *~~

~~"Step therapy." A course of treatment where certain designated drugs or treatment protocols must be either contraindicated or used and found to be ineffective prior to approval of coverage for other designated drugs. The term does not include requests for coverage of nonformulary drugs.~~

~~"Urgent health care service." A covered health care service subject to prior authorization that is delivered on an expedited basis for the treatment of an acute condition with symptoms of sufficient severity pursuant to a determination by a duly licensed and board certified treating physician, operating within the individual's scope of practice and professional expertise, that the absence of such significant medical intervention is likely to result in serious, long term health complications or a material deterioration in the enrollee's condition and prognosis.~~

~~"Utilization review." A system of [prospective, concurrent] prior authorization, concurrent utilization review or retrospective utilization review performed by [a] an insurer, MCO, contractor or utilization review entity on behalf of an insurer, MCO or contractor of the medical necessity [and], appropriateness, health care setting and level of care or effectiveness 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~~

1 ~~health care service verification.~~

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

5 ~~"Utilization review entity." Any entity certified pursuant~~
6 ~~to subdivision (h) that performs utilization review on behalf of~~
7 ~~[a managed care plan] an insurer, MCO or contractor.~~

8 ~~Section 2. Subarticle (b) heading of Article XXI and~~
9 ~~sections 2111, 2112 and 2113 of the act are amended to read:~~

10 ~~(b) [Managed Care Plan] Insurer, MCO and Contractor~~
11 ~~Requirements.~~

12 ~~Section 2111. Responsibilities of [Managed Care Plans]~~
13 ~~Insurer, MCOs and Contractors. [A managed care plan] An~~
14 ~~insurer, MCO or contractor shall do all of the following:~~

15 ~~(1) Assure availability and accessibility of adequate health~~
16 ~~care providers in a timely manner, which enables enrollees to~~
17 ~~have access to quality care and continuity of health care~~
18 ~~services.~~

19 ~~(2) Consult with health care providers in active clinical~~
20 ~~practice regarding professional qualifications and necessary~~
21 ~~specialists to be included in the [plan] health insurance~~
22 ~~policy, MCO contract or CHIP contract.~~

23 ~~(3) Adopt and maintain a definition of medical necessity~~
24 ~~used by the [plan] health insurance policy, MCO contract or CHIP~~
25 ~~contract in determining health care services.~~

26 ~~(4) Ensure that emergency services are provided twenty four~~
27 ~~(24) hours a day, seven (7) days a week and provide reasonable~~
28 ~~payment or reimbursement for emergency services.~~

29 ~~(5) Adopt and maintain procedures by which an enrollee can~~
30 ~~obtain health care services outside the [plan's] health~~

~~insurance policy's, MCO contract's or CHIP contract's service area.~~

~~(6) Adopt and maintain procedures by which an enrollee with a life threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the [plan's] insurer's, MCO's or contractor's established standards are met, be permitted to receive:~~

~~(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or~~

~~(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.~~

~~The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the [managed care plan] insurer, MCO or contractor in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the [plan] health insurance policy, MCO contract or CHIP contract.~~

~~(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the [plan] health insurance policy, MCO contract or CHIP contract to obtain maternity and gynecological care, including medically necessary and appropriate follow up care and referrals for diagnostic testing related to maternity and gynecological care, without prior approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.~~

~~(8) Adopt and maintain a complaint process as set forth in subdivision (g).~~

~~(9) Adopt and maintain a grievance process as set forth in subdivision (i).~~

~~(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).~~

~~(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).~~

~~(12) Provide a list of health care providers participating in the [plan] health insurance policy, MCO contract or CHIP contract to the department every two (2) years or as may otherwise be required by the department. The list shall include the extent to which [health care] participating providers [in the plan] are accepting new enrollees.~~

~~(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the [plan] insurer, MCO or contractor.~~

~~Section 2112. Financial Incentives Prohibition. No [managed care plan] insurer, MCO or contractor shall use any financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee. Nothing in this section shall be deemed to prohibit [a managed care plan] an insurer, MCO or contractor from using a capitated payment arrangement or other risk sharing arrangement.~~

1 ~~Section 2113. Medical Gag Clause Prohibition. (a) No~~
2 ~~[managed care plan] insurer, MCO or contractor may penalize or~~
3 ~~restrict a health care provider from discussing:~~

4 ~~(1) the process that the [plan] insurer, MCO or contractor~~
5 ~~or any entity contracting with the [plan] insurer, MCO or~~
6 ~~contractor uses or proposes to use to deny payment for a health~~
7 ~~care service;~~

8 ~~(2) medically necessary and appropriate care with or on~~
9 ~~behalf of an enrollee, including information regarding the~~
10 ~~nature of treatment; risks of treatment; alternative treatments;~~
11 ~~or the availability of alternate therapies, consultation or~~
12 ~~tests; or~~

13 ~~(3) the decision of any [managed care plan] insurer, MCO or~~
14 ~~contractor to deny payment for a health care service.~~

15 ~~(b) A provision to prohibit or restrict disclosure of~~
16 ~~medically necessary and appropriate health care information~~
17 ~~contained in a contract with a health care provider is contrary~~
18 ~~to public policy and shall be void and unenforceable.~~

19 ~~(c) No [managed care plan] insurer, MCO or contractor shall~~
20 ~~terminate the employment of or a contract with a health care~~
21 ~~provider for any of the following:~~

22 ~~(1) Advocating for medically necessary and appropriate~~
23 ~~health care consistent with the degree of learning and skill~~
24 ~~ordinarily possessed by a reputable health care provider~~
25 ~~practicing according to the applicable legal standard of care.~~

26 ~~(2) Filing a grievance pursuant to the procedures set forth~~
27 ~~in this article.~~

28 ~~(3) Protesting a decision, policy or practice that the~~
29 ~~health care provider, consistent with the degree of learning and~~
30 ~~skill ordinarily possessed by a reputable health care provider~~

~~practicing according to the applicable legal standard of care,
reasonably believes interferes with the health care provider's
ability to provide medically necessary and appropriate health
care.~~

~~(d) Nothing in this section shall:~~

~~(1) Prohibit [a managed care plan] an insurer, MCO or
contractor from making a determination not to pay for a
particular medical treatment, supply or service, enforcing
reasonable peer review or utilization review protocols or making
a determination that a health care provider has or has not
complied with appropriate protocols.~~

~~(2) Be construed as requiring [a managed care plan] an
insurer, MCO or contractor to provide, reimburse for or cover
counseling, referral or other health care services if the [plan]
insurer, MCO or contractor:~~

~~(i) objects to the provision of that service on moral or
religious grounds; and~~

~~(ii) makes available information on its policies regarding
such health care services to enrollees and prospective
enrollees.~~

~~Section 3. Section 2116(a) and (b) of the act are amended
and the section is amended by adding a subsection to read:~~

~~Section 2116. Emergency Services. (a) If an enrollee seeks
emergency services and the emergency health care provider
determines that emergency services are necessary, the emergency
health care provider shall initiate necessary intervention to
evaluate and, if necessary, stabilize the condition of the
enrollee without seeking or receiving authorization from the
[managed care plan. The managed care plan] insurer, MCO or
contractor. No insurer, MCO or contractor shall require a health~~

~~care provider to submit a request for prior authorization for an emergency service. The insurer, MCO or contractor shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles[.], including testing and other diagnostic services that are medically necessary to evaluate or treat an emergency medical condition prior to the point at which the condition is stabilized. When processing a reimbursement claim for emergency services, [a managed care plan] an insurer, MCO or contractor shall consider both the presenting symptoms and the services provided. The [emergency] health care provider shall notify the enrollee's [managed care plan] insurer, MCO or contractor of the provision of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary. If an enrollee is admitted to inpatient care or placed in observation immediately following receipt of a covered emergency service, the inpatient facility shall have a minimum of twenty four (24) hours to notify the enrollee's insurer, MCO or contractor of the admission or placement with such timeframe to start at the later of:~~

- ~~(1) the time of the inpatient admission or placement; or~~
- ~~(2) in the case of an enrollee that is unconscious, comatose or otherwise unable to effectively communicate pertinent information, the time at which the inpatient facility knew or reasonably should have known, through diligent efforts, the identity of the enrollee's insurer, MCO or contractor.~~

~~(b) For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the [managed care plan] insurer, MCO or contractor may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.~~

~~* * *~~

~~(c) Nothing in this section shall require an insurer, MCO or contractor to waive application of otherwise applicable clinical review criteria.~~

~~Section 4. Section 2117 of the act is amended to read:~~

~~Section 2117. Continuity of Care. (a) Except as provided under subsection (b), if [a managed care plan] an insurer, MCO or contractor initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to sixty (60) days from the date the enrollee was notified by the [plan] insurer, MCO or contractor of the termination or pending termination. The [managed care plan] insurer, MCO or contractor, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the [managed care plan] insurer, MCO or contractor~~

~~under the same terms and conditions as applicable for participating health care providers.~~

~~(b) If the [plan] insurer, MCO or contractor terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the [plan] insurer, MCO or contractor, the [plan] insurer, MCO or contractor shall not be responsible for health care services provided to the enrollee following the date of termination.~~

~~(c) If the [plan] insurer, MCO or contractor terminates the contract of a participating primary care provider, the [plan] insurer, MCO or contractor shall notify every enrollee served by that provider of the [plan's] insurer's, MCO's or contractor's termination of its contract and shall request that the enrollee select another primary care provider.~~

~~(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to sixty (60) days from the effective date of enrollment in a [managed care plan] health insurance policy, MCO contract or CHIP contract. The [managed care plan] insurer, MCO or contractor, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the [managed care plan] insurer, MCO or contractor under the same terms and conditions as applicable for~~

1 ~~participating health care providers.~~

2 ~~(e) [A plan] An insurer, MCO or contractor may require a~~
3 ~~nonparticipating health care provider whose health care services~~
4 ~~are covered under this section to meet the same terms and~~
5 ~~conditions as a participating health care provider.~~

6 ~~(f) Nothing in this section shall require [a managed care~~
7 ~~plan] an insurer, MCO or contractor to provide health care~~
8 ~~services that are not otherwise covered under the terms and~~
9 ~~conditions of the [plan] health insurance policy, MCO contract~~
10 ~~or CHIP contract.~~

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

12 ~~Section 2118. Medication assisted treatment. (a) An~~
13 ~~insurer, MCO or contractor shall make available without initial~~
14 ~~prior authorization coverage of at least one United States Food~~
15 ~~and Drug Administration approved prescription drug classified as~~
16 ~~Medication Assisted Treatment.~~

17 ~~(b) Nothing in this section shall prohibit an insurer, MCO~~
18 ~~or contractor from designating preferred medications for the~~
19 ~~relevant component of medication assisted treatment when~~
20 ~~multiple medications are available, subject to applicable~~
21 ~~requirements for documenting and posting any relevant medical~~
22 ~~policy or prescription drug formulary information.~~

23 ~~(c) With the exception of prior authorization for initial~~
24 ~~coverage, nothing in this section shall prohibit an insurer, MCO~~
25 ~~or contractor from requiring prior authorization on subsequent~~
26 ~~requests for medication assisted treatment to ensure adherence~~
27 ~~with clinical guidelines.~~

28 ~~Section 6. Sections 2121, 2131 and 2136 of the act are~~
29 ~~amended to read:~~

30 ~~Section 2121. Procedures. (a) [A managed care plan] An~~

~~insurer, MCO or contractor shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.~~

~~(b) The department shall establish credentialing standards for [managed care plans.] insurers, MCOs and contractors. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for [managed care plans] insurers, MCOs and contractors.~~

~~(c) [A managed care plan] An insurer, MCO or contractor shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.~~

~~(d) [A managed care plan] An insurer, MCO or contractor shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the [plan's] insurer's, MCO's or contractor's provider network. [A managed care plan] An insurer, MCO or contractor shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of [a managed care plan] an insurer, MCO or contractor shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."~~

~~(e) No [managed care plan] insurer, MCO or contractor shall exclude or terminate a health care provider from participation in the [plan] health insurance policy, MCO contract or CHIP contract due to any of the following:~~

~~(1) The health care provider engaged in any of the activities set forth in section 2113(c).~~

~~(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.~~

~~(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.~~

~~(f) If [a managed care plan] an insurer, MCO or contractor denies enrollment or renewal of credentials to a health care provider, the [managed care plan] insurer, MCO or contractor shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.~~

~~Section 2131. Confidentiality. (a) [A managed care plan] An insurer, MCO, contractor and a utilization review entity shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis and treatment is adequately protected and remains confidential in compliance with all applicable Federal and State laws and regulations and professional ethical standards.~~

~~(b) To the extent [a managed care plan] an insurer, MCO or contractor maintains medical records, the [plan] insurer, MCO or contractor shall adopt and maintain procedures to ensure that enrollees have timely access to their medical records unless prohibited by Federal or State law or regulation.~~

~~(c) (1) Information regarding an enrollee's health or treatment shall be available to the enrollee, the enrollee's designee or as necessary to prevent death or serious injury.~~

~~(2) Nothing in this section shall:~~

1 ~~(i) Prevent disclosure necessary to determine coverage,~~
2 ~~review complaints or grievances, conduct utilization review or~~
3 ~~facilitate payment of a claim.~~

4 ~~(ii) Deny the department, the Insurance Department or the~~
5 ~~Department of [Public Welfare] Human Services access to records~~
6 ~~for purposes of quality assurance, investigation of complaints~~
7 ~~or grievances, enforcement or other activities related to~~
8 ~~compliance with this article and other laws of this~~
9 ~~Commonwealth. Records shall be accessible only to department~~
10 ~~employees or agents with direct responsibilities under the~~
11 ~~provisions of this subparagraph.~~

12 ~~(iii) Deny access to information necessary for a utilization~~
13 ~~review entity to conduct a review under this article.~~

14 ~~(iv) Deny access to the [managed care plan] insurer, MCO or~~
15 ~~contractor for internal quality review, including reviews~~
16 ~~conducted as part of the [plan's] insurer's, MCO's and~~
17 ~~contractor's quality oversight process. During such reviews,~~
18 ~~enrollees shall remain anonymous to the greatest extent~~
19 ~~possible.~~

20 ~~(v) Deny access to [managed care plans] insurers, MCOs,~~
21 ~~contractors, health care providers and their respective~~
22 ~~designees for the purpose of providing patient care management,~~
23 ~~outcomes improvement and research. For this purpose, enrollees~~
24 ~~shall provide consent and shall remain anonymous to the greatest~~
25 ~~extent possible.~~

26 Section 2136. Required Disclosure. (a) ~~[A managed care~~
27 ~~plan] An insurer, MCO or contractor shall supply each enrollee~~
28 ~~and, upon written request, each prospective enrollee or health~~
29 ~~care provider with the following written information. Such~~
30 ~~information shall be easily understandable by the layperson and~~

1 ~~shall include, but not be limited to:~~

2 ~~(1) A description of coverage, benefits and benefit~~
3 ~~maximums, including benefit limitations and exclusions of~~
4 ~~coverage, health care services and the definition of medical~~
5 ~~necessity used by the [plan] health insurance, MCO contract or~~
6 ~~CHIP contract in determining whether these benefits will be~~
7 ~~covered. The following statement shall be included in all~~
8 ~~marketing materials in boldface type:~~

9 ~~This [managed care plan] health insurance policy or contract~~
10 ~~may not cover all your health care expenses. Read your~~
11 ~~contract carefully to determine which health care services~~
12 ~~are covered.~~

13 ~~The notice shall be followed by a telephone number to contact~~
14 ~~the [plan] insurer, MCO or contractor.~~

15 ~~(2) A description of all necessary prior authorizations or~~
16 ~~other requirements for nonemergency health care services as~~
17 ~~required in section 2154(b).~~

18 ~~(3) An explanation of an enrollee's financial responsibility~~
19 ~~for payment of premiums, coinsurance, copayments, deductibles~~
20 ~~and other charges, annual limits on an enrollee's financial~~
21 ~~responsibility and caps on payments for health care services~~
22 ~~provided under the [plan] health insurance policy, MCO contract~~
23 ~~or CHIP contract.~~

24 ~~(4) An explanation of an enrollee's financial responsibility~~
25 ~~for payment when a health care service is provided by a~~
26 ~~nonparticipating health care provider, when a health care~~
27 ~~service is provided by any health care provider without required~~
28 ~~authorization or when the care rendered is not covered by the~~
29 ~~[plan] health insurance policy, MCO contract or CHIP contract.~~

30 ~~(5) A description of how the [managed care plan] insurer,~~

~~MCO or contractor addresses the needs of non-English speaking enrollees.~~

~~(6) A notice of mailing addresses and telephone numbers necessary to enable an enrollee to obtain approval or authorization of a health care service or other information regarding the [plan] health insurance policy, MCO contract or CHIP contract.~~

~~(7) A summary of the [plan's] health insurance policy's, MCO contract's or CHIP contract's utilization review policies and procedures.~~

~~(8) A summary of all complaint and grievance procedures used to resolve disputes between the [managed care plan] insurer, MCO contractor and an enrollee or a health care provider, including:~~

~~(i) The procedure to file a complaint or grievance as set forth in this article, including a toll free telephone number to obtain information regarding the filing and status of a complaint or grievance.~~

~~(ii) The right to appeal a decision relating to a complaint or grievance.~~

~~(iii) The enrollee's right to designate a representative to participate in the complaint or grievance process as set forth in this article.~~

~~(iv) A notice that all disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice and that all notices of decisions will include information regarding the basis for the determination.~~

~~(9) A description of the procedure for providing emergency services twenty four (24) hours a day. The description shall include:~~

~~(i) A definition of emergency services as set forth in this article.~~

~~(ii) Notice that emergency services are not subject to prior approval.~~

~~(iii) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the [managed care plan's] insurer's, MCO's or contractor's service area.~~

~~(10) A description of the procedures for enrollees to select a participating health care provider, including how to determine whether a participating health care provider is accepting new enrollees.~~

~~(11) A description of the procedures for changing primary care providers and specialists.~~

~~(12) A description of the procedures by which an enrollee may obtain a referral to a health care provider outside the provider network when that provider network does not include a health care provider with appropriate training and experience to meet the health care service needs of an enrollee.~~

~~(13) A description of the procedures that an enrollee with a life threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:~~

~~(i) a standing referral to a specialist with clinical expertise in treating the disease or condition; or~~

~~(ii) the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.~~

~~(14) A list by specialty of the name, address and telephone number of all participating health care providers. The list may be a separate document and shall be updated at least annually.~~

~~(15) A list of the information available to enrollees or~~

~~prospective enrollees, upon written request, under subsection (b).~~

~~(b) Each [managed care plan] insurer, MCO or contractor shall, upon written request of an enrollee or prospective enrollee, provide the following written information:~~

~~(1) A list of the names, business addresses and official positions of the membership of the board of directors or officers of the [managed care plan] insurer, MCO or contractor.~~

~~(2) The procedures adopted to protect the confidentiality of medical records and other enrollee information.~~

~~(3) A description of the credentialing process for health care providers.~~

~~(4) A list of the participating health care providers affiliated with participating hospitals.~~

~~(5) Whether a specifically identified drug is included or excluded from coverage.~~

~~(6) A description of the process by which a health care provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.~~

~~(7) A description of the procedures followed by the [managed care plan] insurer, MCO or contractor to make decisions about the experimental nature of individual drugs, medical devices or treatments.~~

~~(8) A summary of the methodologies used by the [managed care plan] insurer, MCO or contractor to reimburse for health care services. Nothing in this paragraph shall be construed to~~

~~require disclosure of individual contracts or the specific details of any financial arrangement between [a managed care plan] an insurer, MCO, contractor and a health care provider.~~

~~(9) A description of the procedures used in the [managed care plan's] insurer's, MCO's or contractor's quality assurance program.~~

~~(10) Other information as may be required by the department or the Insurance Department.~~

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

~~Section 2137. Medical policy and clinical review criteria adopted by an insurer, MCO or contractor. (a) An insurer, MCO or contractor shall make available its current medical policies on the insurer's, MCO's and contractor's publicly accessible Internet website or provider portal. The insurer's, MCO's or contractor's medical policies shall include reference to the clinical review criteria used in developing the medical policy. If an insurer's, MCO's or contractor's medical policy incorporates licensed third party standards that also limit the insurer's, MCO's or contractor's ability to publish those standards in full, the insurer's, MCO's or contractor's posted policies shall clearly identify these sources.~~

~~(b) An insurer, MCO or contractor shall review each adopted medical policy on at least an annual basis.~~

~~(c) An insurer, MCO or contractor shall notify health care providers of discretionary changes to medical policies at least thirty (30) days prior to application of the changes. The following apply:~~

~~(1) In the case of policy changes due to changes in Federal or State law, regulation or binding agency guidance, an insurer, MCO or contractor shall notify health care providers at least~~

~~thirty (30) days prior to the application of the changes, except that in cases where the timing of changes in binding guidance makes such advance notice impracticable, an insurer, MCO or contractor shall make commercially reasonable efforts to notify providers of such changes prior to their application.~~

~~(2) Notification of changes may be provided through the posting of an updated and dated medical policy reflecting the change or through other reasonable means.~~

~~(3) In the case of changes to medical policies that modify, eliminate or suspend either clinical or administrative criteria and that directly result in less restrictive coverage of a given service, an insurer, MCO or contractor shall notify health care providers within (30) days after application of such change.~~

~~(d) Clinical review criteria adopted by an insurer, MCO or contractor at the time of medical policy development or review shall:~~

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

~~(2) Be consistent with applicable governmental guidelines.~~

~~(3) Provide for the delivery of a health care service in a clinically appropriate type, frequency, setting and duration.~~

~~(4) Reflect the current quality of medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer reviewed medical literature.~~

~~(e) Nothing in this section shall require an insurer, MCO or contractor to provide coverage for a health care service that is otherwise excluded from coverage under a health insurance policy, MCO contract or CHIP contract.~~

~~Section 8. Sections 2141, 2142(a) and (b), 2143, 2151(e) and 2152(a)(3), (4)(i) and (7) and (c) of the act are amended to~~

1 read:

2 Section 2141. Internal Complaint Process. (a) ~~[A managed~~
3 ~~care plan] An insurer, MCO or contractor shall establish and~~
4 ~~maintain an internal complaint process [with two levels of~~
5 ~~review] by which an enrollee shall be able to file a complaint~~
6 ~~[regarding a participating health care provider or the coverage,~~
7 ~~operations or management policies of the managed care plan].~~

8 (b) ~~The complaint process shall consist of [an initial] a~~
9 ~~review [to] by a committee of three or more individuals, a third~~
10 ~~of which shall not be employed by the insurer, MCO or contractor~~
11 ~~and shall include all of the following:~~

12 ~~[(1) A review by an initial review committee consisting of~~
13 ~~one or more employees of the managed care plan.]~~

14 ~~(2) The allowance of a written or oral complaint.~~

15 ~~(3) The allowance of written data or other information.~~

16 ~~(4) A review or investigation of the complaint which shall~~
17 ~~be completed within thirty (30) days of receipt of the~~
18 ~~complaint.~~

19 ~~(5) A written notification to the enrollee regarding the~~
20 ~~decision of the [initial] review committee within five (5)~~
21 ~~business days of the decision. [Notice shall include the basis~~
22 ~~for the decision and the procedure to file a request for a~~
23 ~~second level review of the decision of the initial review~~
24 ~~committee.~~

25 ~~(c) The complaint process shall include a second level~~
26 ~~review that includes all of the following:~~

27 ~~(1) A review of the decision of the initial review committee~~
28 ~~by a second level review committee consisting of three or more~~
29 ~~individuals who did not participate in the initial review. At~~
30 ~~least one third of the second level review committee shall not~~

1 ~~be employed by the managed care plan.~~

2 ~~(2) A written notification to the enrollee of the right to~~
3 ~~appear before the second level review committee.~~

4 ~~(3) A requirement that the second level review be completed~~
5 ~~within forty five (45) days of receipt of a request for such~~
6 ~~review.~~

7 ~~(4) A written notification to the enrollee regarding the~~
8 ~~decision of the second level review committee within five (5)~~
9 ~~business days of the decision.] The notice shall include the~~
10 ~~basis for the decision and the procedure for appealing the~~
11 ~~decision to the department or the Insurance Department.~~

12 ~~Section 2142. Appeal of Complaint. (a) An enrollee shall~~
13 ~~have [fifteen (15) days] four (4) months from receipt of the~~
14 ~~notice of the decision from the [second level] review committee~~
15 ~~to appeal the decision to the department or the Insurance~~
16 ~~Department, as appropriate.~~

17 ~~(b) All records from the [initial] review [and second level~~
18 ~~review] shall be transmitted to the appropriate department in~~
19 ~~the manner prescribed. The enrollee, the health care provider or~~
20 ~~the [managed care plan] insurer, MCO or contractor may submit~~
21 ~~additional materials related to the complaint.~~

22 ~~* * *~~

23 ~~Section 2143. Complaint Resolution. Nothing in this~~
24 ~~subdivision shall prevent the department or the Insurance~~
25 ~~Department from communicating with the enrollee, the health care~~
26 ~~provider or the [managed care plan] insurer, MCO or contractor~~
27 ~~as appropriate to assist in the resolution of a complaint. Such~~
28 ~~communication may occur at any time during the complaint~~
29 ~~process.~~

30 ~~Section 2151. Certification. * * *~~

1 ~~(e) [A licensed] An insurer [or a managed care plan], MCO or~~
2 ~~contractor with a certificate of authority shall comply with the~~
3 ~~standards and procedures of this subdivision but shall not be~~
4 ~~required to obtain separate certification as a utilization~~
5 ~~review entity.~~

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

8 ~~* * *~~

9 ~~(3) Ensure that a health care provider is able to verify~~
10 ~~that an individual requesting information on behalf of the~~
11 ~~[managed care plan] insurer, MCO or contractor is a legitimate~~
12 ~~representative of the [plan] insurer, MCO or contractor.~~

13 ~~(4) Conduct utilization reviews based on the medical~~
14 ~~necessity [and], appropriateness, health care setting, level of~~
15 ~~care or effectiveness of the health care service being reviewed~~
16 ~~and provide notification within the following time frames:~~

17 ~~(i) A [prospective utilization review] prior authorization~~
18 ~~decision shall be communicated [within two (2) business days of~~
19 ~~the receipt of all supporting information reasonably necessary~~
20 ~~to complete the review.] pursuant to the review timelines~~
21 ~~contained in section 2154(g).~~

22 ~~* * *~~

23 ~~(7) Notify the health care provider of additional facts or~~
24 ~~documents required to complete the utilization review within~~
25 ~~forty eight (48) hours of receipt of the request for review[.]~~
26 ~~or pursuant to section 2154(h) for missing clinical information~~
27 ~~for all requests for prior authorization.~~

28 ~~* * *~~

29 ~~(c) Utilization review that results in a denial of payment~~
30 ~~for a health care service, not including an administrative~~

~~denial, shall be made by a licensed physician, except as provided in subsection (d) or section 2154(c) for all requests for prior authorization.~~

~~* * *~~

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

~~Section 2153. Step Therapy Considerations. The following:~~

~~(1) If an insurer's, MCO's or contractor's medical policy adopted under section 2137 incorporates step therapy criteria for prescription drugs, an insurer, MCO or contractor shall consider as part of the insurer's, MCO's or contractor's initial prior authorization process or a request for an exception to the insurer's, MCO's or contractors step therapy criteria, and based on the enrollee's individualized clinical condition, the following:~~

~~(i) Contraindications, including adverse reactions.~~

~~(ii) Clinical effectiveness or ineffectiveness of the required prerequisite prescription drugs or therapies.~~

~~(iii) Past clinical outcome of the required prerequisite prescription drug or therapy.~~

~~(iv) The expected clinical outcomes of the requested prescription drug prescribed by the enrollee's health care provider.~~

~~(v) For new enrollees, whether the enrollee has already satisfied a step therapy protocol with their previous health insurer that required trials of drugs from each of the classes that are required by the current insurer's, MCO's or contractor's step therapy protocol.~~

~~(2) The provisions of section 2154 shall apply to step therapy reviews conducted under this section.~~

~~Section 2154. Prior Authorization Review. (a) (1)~~

~~Insurer, MCO or contractor review of a request for prior authorization shall be based upon the insurer's, MCO's or contractor's medical policy, administrative policy and all medical information and evidence submitted by the requesting provider.~~

~~(2) At the time of review, an insurer, MCO or contractor shall also verify the enrollee's eligibility for coverage under the terms of the applicable health insurance policy, MCO contract or CHIP contract.~~

~~(3) Appeals of administrative denials shall be subject to the complaint process under subarticle (g).~~

~~(b) An insurer, MCO or contractor shall make available a list, posted in a publicly accessible format and location on the insurer's, MCO's or contractor's publicly accessible Internet website, and provider portal, that indicates the health services for which the insurer, MCO or contractor requires prior authorization.~~

~~(c) Other than an administrative denial, a request for prior authorization may only be denied upon review by a properly licensed medical professional with appropriate training, knowledge or experience in the same or similar specialty that typically manages or consults on the health care service in question. Alternatively, an insurer, MCO or contractor may satisfy this requirement through the completion of the review by a licensed medical professional in consultation with an appropriately qualified third party medical professional, licensed in the same or similar medical specialty as the requesting health care provider or type of health care provider that typically manages the enrollee's associated condition, provided that any compensation paid to the consulting~~

~~professional may not be contingent upon the outcome of the review. Nothing in this section shall compel an insurer, MCO or contractor to obtain third party medical professionals in the same specialty or subspecialty.~~

~~(d) In the case of a denied prior authorization, the insurer, MCO or contractor shall make available to the requesting health care provider a licensed medical professional for a peer to peer review discussion. The peer to peer reviewer provided by the insurer, MCO or contractor shall meet the standards under subsection (c) and have authority to modify or overturn the prior authorization decision. The procedure for requesting a peer to peer review shall be available on the insurer's, MCO's or contractor's publicly accessible Internet website and provider portal. An insurer's, MCO's or contractor's peer to peer procedure shall include, but not be limited to, ability to request a peer to peer discussion:~~

~~(1) during normal business hours; or~~

~~(2) outside normal business hours subject to reasonable limitations on the availability of qualified insurer, MCO or contractor staff. In the event an insurer, MCO or contractor uses a third party vendor or utilization review entity to conduct peer to peer reviews for denials administered by the vendor or entity, the procedure under subsection (i) shall include contact information and information on the hours of availability of the vendor or entity necessary for a requesting health care provider to schedule a peer to peer discussion.~~

~~(e) A health care provider may designate, and an insurer, MCO or contractor shall accept, another licensed member of the health care provider's affiliated or employed clinical staff with knowledge of the enrollee's condition and requested~~

~~procedure as a qualified proxy for purposes of completing a peer to peer discussion. Individuals eligible to receive a proxy designation shall be limited to licensed health care providers whose actual authority and scope of practice is inclusive of performing or prescribing the requested health care service. Such authority may be established through a supervising physician consistent with applicable State law for non physician practitioners. The insurer, MCO or contractor must accept and review the information submitted by other members of a health care provider's affiliated or employed staff in support of a prior authorization request. The insurer, MCO or contractor may not limit interactions with an insurer's, MCO's or contractor's clinical staff solely to the requesting health care provider.~~

~~(f) A peer to peer discussion shall be available to a requesting health care provider from the time of a denial of prior authorization until the internal grievance process commences. If a peer to peer discussion is available prior to adjudicating a prior authorization request, the peer to peer shall be offered within the timeline in subsection (g).~~

~~(g) An insurer's, MCO's or contractor's decision to approve or deny prior authorization shall be rendered within the following timeframes and following the submission of a complete prior authorization request:~~

~~(1) An insurer, MCO or contractor shall issue a prior authorization determination for a medical health care service in accordance with the following timeframes:~~

~~(i) Review of request for urgent health care services as expeditiously as the enrollee's health condition requires but no more than seventy two (72) hours.~~

~~(ii) Review of request for non urgent medical services not~~

~~more than fifteen (15) calendar days.~~

~~(2) Insurers, MCOs and contractors shall issue a prior authorization determination for a prescription drug medication or render a decision on step therapy under section 2153 in accordance with the following timeframes:~~

~~(i) Review or urgent request not more than twenty four (24) hours.~~

~~(ii) Review of standard request not more than two (2) business days and not to exceed seventy two (72) hours.~~

~~(3) If at any time after requesting prior authorization the health care provider determines the enrollee's medical condition requires emergency services, such services may be provided under section 2116.~~

~~(4) Upon receipt of a submission of a prior authorization request, an insurer, MCO or contractor shall notify the health care provider of any missing or other supporting information necessary to make it a complete prior authorization request in accordance with subsection (h).~~

~~(h) In the event that a prior authorization request is missing clinical information that is reasonably necessary to complete a review, the insurer, MCO or contractor shall notify the health care provider of any missing clinical information necessary to complete the review within twenty four (24) hours of receipt of the prior authorization request for urgent health care services or within two (2) business days of receipt of all other types of prior authorization requests and allow the requesting health care provider or any member of the requesting health care provider's clinical or administrative staff to submit such information within the established review time lines. A request for information under this subsection shall be~~

~~made with sufficient specificity to enable the health care provider to identify the necessary clinical or other supporting information necessary to complete review.~~

~~(i) An insurer, MCO or contractor may supplement submitted information based on current clinical records or other current medical information for an enrollee as available, provided that the supplemental information is also made available to the enrollee or health care provider as part of the enrollee's authorization case file upon request. In response to any request for missing information, an insurer, MCO or contractor shall also accept supplemental information from any member of the health care provider's clinical staff.~~

~~(j) If a health care provider performs a closely related service, the insurer, MCO or contractor may not deny a claim for the closely related service for failure of the health care provider to seek or obtain prior authorization, provided that:~~

~~(1) The health care provider notifies the insurer, MCO or contractor of the performance of the closely related service no later than seventy two (72) hours following completion of the service but prior to the submission of the claim for payment. The submission of the notification shall include the submission of all relevant clinical information necessary for the insurer, MCO or contractor to evaluate the medical necessity and appropriateness of the service.~~

~~(2) Nothing in this subsection shall be construed to limit an insurer's, MCO's or contractor's consideration of medical necessity and appropriateness of the closely service, nor limit the need for verification of the enrollee's eligibility for coverage.~~

~~Section 2155. Provider portal. (a) Within eighteen (18)~~

~~months following the effective date of this section, an insurer, MCO or contractor shall establish a provider portal that includes, at minimum, the following features:~~

~~(1) Electronic submission of prior authorization requests.~~

~~(2) Access to an insurer's, MCO's or contractor's applicable medical policies.~~

~~(3) Information necessary to request a peer to peer review.~~

~~(4) Contact information for an insurer's, MCO's or contractor's relevant clinical or administrative staff.~~

~~(5) For any prior authorization service not subject to electronic submission via the provider portal, copies of any applicable submission forms.~~

~~(6) Instructions for the submission of prior authorization requests in the event that an insurer's, MCO's or contractor's provider portal is unavailable for any reason.~~

~~(b) Within six (6) months following the establishment of provider portals under subsection (a), an insurer, MCO or contractor shall make available to health care providers and their affiliated or employed staff access to training on the use of the insurer's, MCO's or contractor's provider portal.~~

~~(c) Within eighteen (18) months following the establishment of provider portals under subsection (a), a health care provider seeking prior authorization shall submit such request via an insurer's, MCO's or contractor's provider portal, provided that:~~

~~(1) Submission via provider portal shall only be required to the extent an insurer's, MCO's or contractor's provider portal is available and operational at the time of attempted submission.~~

~~(2) Submission via an insurer's, MCO's or contractor's provider portal shall only be required to the extent the health~~

~~care provider has access to the insurer's, MCO's or contractor's operational provider portal.~~

~~(3) Insurers, MCOs and contractors may elect to maintain allowances for submission of prior authorization requests outside of the provider portal.~~

~~Section 10. Sections 2161, 2162, 2163, 2166, subarticle (k) heading of Article XXI and sections 2171, 2181, 2182 and 2191 of the act are amended to read:~~

~~Section 2161. Internal Grievance Process. (a) [A managed care plan] An insurer, MCO or contractor shall establish and maintain an internal grievance process [with two levels of review] and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service within four (4) months of receiving an adverse benefit determination. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.~~

~~(b) The internal grievance process shall consist of [an initial] a review that includes all of the following:~~

~~(1) A review by [one] three or more persons selected by the [managed care plan] insurer, MCO or contractor who did not previously participate in the decision to deny payment for the health care service.~~

~~(2) The completion of the review within thirty (30) days of receipt of the grievance.~~

~~(3) A written notification to the enrollee and health care provider[.] of the right to appear before the review committee within five (5) business days of receiving the internal~~

grievance.

~~(4) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request [for a second level review of] appealing the decision as an external grievance.~~

~~[(c) The grievance process shall include a second level review that includes all of the following:~~

~~(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.~~

~~(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.~~

~~(3) The completion of the second level review within forty five (45) days of receipt of a request for such review.~~

~~(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.]~~

~~(d) Any [initial review or second level] review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.~~

~~(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance~~

~~process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee and health care provider be made within forty eight (48) hours of the filing of the expedited grievance.~~

~~Section 2162. External Grievance Process. (a) [A managed care plan] An insurer, MCO or contractor shall establish and maintain an external grievance process by which an enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with the [managed care plan] insurer, MCO or contractor.~~

~~(b) To conduct external grievances filed under this section:~~

~~(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the [managed care plan] insurer, MCO or contractor within two (2) business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the [managed care plan] insurer, MCO or contractor shall designate and notify a certified utilization review entity to conduct the external grievance.~~

~~(2) The [managed care plan] insurer, MCO or contractor shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.~~

~~(c) The external grievance process shall meet all of the following requirements:~~

~~(1) Any external grievance shall be filed with the [managed~~

~~care plan] insurer, MCO or contractor within [fifteen (15) days] four (4) months of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the [managed care plan] insurer, MCO or contractor shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.~~

~~(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.~~

~~(3) The utilization review entity conducting the external grievance shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.~~

~~(4) An external grievance decision shall be made by:~~
~~(i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment~~

~~for the health care service being reviewed; or~~

~~(ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.~~

~~(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the [managed care plan] insurer, MCO or contractor, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the [plan] health insurance policy, MCO contract or CHIP contract.~~

~~The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in favor of the decision of the utilization review entity conducting the external grievance.~~

~~(6) The [managed care plan] insurer, MCO or contractor shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.~~

~~(7) All fees and costs related to an external grievance shall be paid by the nonprevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or [managed care plan] insurer, MCO or contractor shall each place in escrow an~~

~~amount equal to one half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the [managed care plan] insurer, MCO or contractor. For purposes of this paragraph, fees and costs shall not include attorney fees.~~

~~(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.~~

~~(e) A fee may be imposed by [a managed care plan] an insurer, MCO or contractor for filing an external grievance pursuant to this article which shall not exceed twenty five (\$25) dollars.~~

~~(f) Written contracts between [managed care plans] insurers, MCO or contractor and health care providers may provide an alternative dispute resolution system to the external grievance process set forth in this article if the department approves the contract. The alternative dispute resolution system shall be impartial, include specific time limitations to initiate appeals, receive written information, conduct hearings and render decisions and otherwise satisfy the requirements of this section. A written decision pursuant to an alternative dispute resolution system shall be final and binding on all parties. An alternative dispute resolution system shall not be utilized for any external grievance filed by an enrollee.~~

~~Section 2163. Records. Records regarding grievances filed under this subdivision that result in decisions adverse to~~

1 ~~enrollees shall be maintained by the [plan] insurer, MCO or~~
2 ~~contractor for not less than three (3) years. These records~~
3 ~~shall be provided to the department, if requested, in accordance~~
4 ~~with section 2131(c)(2)(ii).~~

5 ~~Section 2166. Prompt Payment of Claims. (a) [A licensed]~~
6 ~~An insurer [or a managed care plan], MCO or contractor shall pay~~
7 ~~a clean claim submitted by a health care provider within forty~~
8 ~~five (45) days of receipt of the clean claim.~~

9 ~~(b) If [a licensed] an insurer [or a managed care plan], MCO~~
10 ~~or contractor fails to remit the payment as provided under~~
11 ~~subsection (a), interest at ten per centum (10%) per annum shall~~
12 ~~be added to the amount owed on the clean claim. Interest shall~~
13 ~~be calculated beginning the day after the required payment date~~
14 ~~and ending on the date the claim is paid. The licensed insurer~~
15 ~~or [managed care plan] insurer, MCO or contractor shall not be~~
16 ~~required to pay any interest calculated to be less than two (\$2)~~
17 ~~dollars.~~

18 ~~(k) Health Care Provider [and Managed Care Plan], Insurer, MCO~~
19 ~~and Contractor Protection.~~

20 ~~Section 2171. Health Care Provider [and Managed Care Plan],~~
21 ~~Insurer, MCO and Contractor Protection. (a) [A managed care~~
22 ~~plan] An insurer, MCO or contractor shall not exclude,~~
23 ~~discriminate against or penalize any health care provider for~~
24 ~~its refusal to allow, perform, participate in or refer for~~
25 ~~health care services when the refusal of the health care~~
26 ~~provider is based on moral or religious grounds and that~~
27 ~~provider makes adequate information available to enrollees or,~~
28 ~~if applicable, prospective enrollees.~~

29 ~~(b) No public institution, public official or public agency~~
30 ~~may take disciplinary action against, deny licensure or~~

~~certification or penalize any person, association or corporation attempting to establish a [plan] health insurance policy, MCO contract, CHIP contract or operating, expanding or improving an existing [plan] health insurance policy, MCO contract or CHIP contract because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other [plans] health insurance policies, MCO contracts or CHIP contracts when the refusal is based on moral or religious grounds.~~

~~Section 2181. Departmental Powers and Duties. (a) The department shall require that records and documents submitted to [a managed care plan] an insurer, MCO, contractor or utilization review entity as part of any complaint or grievance be made available to the department, upon request, for purposes of enforcement or compliance with this article.~~

~~(b) The department shall compile data received from [a managed care plan] an insurer, MCO or contractor on an annual basis regarding the number, type and disposition of complaints and grievances filed with [a managed care plan] an insurer, MCO or contractor under this article.~~

~~(c) The department shall issue guidelines identifying those provisions of this article that exceed or are not included in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance. These guidelines shall be published in the Pennsylvania Bulletin and updated as necessary. Copies of the guidelines shall be made available to [managed care plans] insurers, MCOs, contractors, health care providers and enrollees upon request.~~

~~(d) The department and the Insurance Department shall ensure~~

~~compliance with this article. The appropriate department shall investigate potential violations of the article based upon information received from enrollees, health care providers and other sources in order to ensure compliance with this article.~~

~~(e) The department and the Insurance Department shall promulgate such regulations as may be necessary to carry out the provisions of this article.~~

~~(f) The department in cooperation with the Insurance Department shall submit an annual report to the General Assembly regarding the implementation, operation and enforcement of this article.~~

~~Section 2182. Penalties and Sanctions. (a) The department or the Insurance Department, as appropriate, may impose a civil penalty of up to five thousand (\$5,000) dollars for a violation of this article.~~

~~(b) [A managed care plan] An insurer, MCO or contractor shall be subject to the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act."~~

~~(c) The department or the Insurance Department may maintain an action in the name of the Commonwealth for an injunction to prohibit any activity which violates the provisions of this article.~~

~~(d) The department may issue an order temporarily prohibiting [a managed care plan] an insurer, MCO or contractor which violates this article from enrolling new members.~~

~~(e) The department may require [a managed care plan] an insurer, MCO or contractor to develop and adhere to a plan of correction approved by the department. The department shall monitor compliance with the plan of correction. The plan of correction shall be available to enrollees of the [managed care~~

~~plan] insurer, MCO or contractor upon request.~~

~~(f) In no event shall the department and the Insurance Department impose a penalty for the same violation.~~

~~Section 2191. Compliance with National Accrediting Standards. Notwithstanding any other provision of this article to the contrary, the department shall give consideration to [a managed care plan's] an insurer's, MCO's or contractor's~~

~~demonstrated compliance with the standards and requirements set forth in the "Standards for the Accreditation of Managed Care Organizations" published by the National Committee for Quality Assurance or other department approved quality review organizations in determining compliance with the same or similar provisions of this article. The [managed care plan] insurer, MCO or contractor, however, shall remain subject to and shall comply with any other provisions of this article that exceed or are not included in the standards of the National Committee for Quality Assurance or other department approved quality review organizations.~~

~~Section 11. This act shall take effect as follows:~~

~~(1) This section shall take effect immediately.~~

~~(2) The addition of section 2155 of the act shall take effect January 1, 2023.~~

~~(3) The remainder of this act shall take effect January 1, 2024.~~

SECTION 1. SECTION 2102, SUBDIVISION (B) HEADING OF ARTICLE XXI, SECTIONS 2111, 2112, 2113, 2116, 2117, 2121 AND 2131, SUBDIVISION (F) HEADING OF ARTICLE XXI AND SECTION 2136 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, ARE AMENDED 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:

"ACTIVE CLINICAL PRACTICE." THE PRACTICE OF CLINICAL
MEDICINE BY A HEALTH CARE PROVIDER FOR AN AVERAGE OF NOT LESS
THAN TWENTY (20) HOURS PER WEEK.

"ADMINISTRATIVE DENIAL." AN ADVERSE BENEFIT DETERMINATION OF
PRIOR AUTHORIZATION, COVERAGE OR PAYMENT BASED ON A LACK OF
ELIGIBILITY, FAILURE TO SUBMIT COMPLETE INFORMATION OR OTHER
FAILURE TO COMPLY WITH AN ADMINISTRATIVE POLICY. THE TERM DOES
NOT INCLUDE AN ADVERSE BENEFIT DETERMINATION BASED ON MEDICAL
NECESSITY.

"ADMINISTRATIVE POLICY." A WRITTEN DOCUMENT OR COLLECTION OF
DOCUMENTS REFLECTING THE TERMS OF THE CONTRACTUAL OR OPERATING
RELATIONSHIP BETWEEN AN INSURER OR MA OR CHIP MANAGED CARE PLAN
AND A HEALTH CARE PROVIDER.

"ADVERSE BENEFIT DETERMINATION." AN ADVERSE BENEFIT
DETERMINATION MAY BE ANY OF THE FOLLOWING:

(1) A DETERMINATION BY AN INSURER OR A UTILIZATION REVIEW
ENTITY ON BEHALF OF AN INSURER THAT, BASED UPON THE INFORMATION
PROVIDED AND UPON APPLICATION OF UTILIZATION REVIEW, A REQUEST
FOR A BENEFIT UNDER A HEALTH INSURANCE POLICY DOES NOT MEET THE
INSURER'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS,
HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OR IS
DETERMINED TO BE EXPERIMENTAL OR INVESTIGATIONAL, SUCH THAT THE
REQUESTED BENEFIT IS THEREFORE DENIED, REDUCED OR TERMINATED OR
PAYMENT IS NOT PROVIDED OR MADE, IN WHOLE OR IN PART, FOR THE
BENEFIT.

(2) THE DENIAL, REDUCTION, TERMINATION OR FAILURE TO PROVIDE
OR MAKE PAYMENT, IN WHOLE OR IN PART, FOR A BENEFIT BASED ON A
DETERMINATION BY AN INSURER OF A PERSON'S ELIGIBILITY FOR

1 COVERAGE UNDER A HEALTH INSURANCE POLICY OR NONCOMPLIANCE WITH
2 AN ADMINISTRATIVE POLICY.

3 (3) A RESCISSION OF COVERAGE DETERMINATION.

4 "AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES." A
5 CONTRACT BETWEEN AN MA OR CHIP MANAGED CARE PLAN AND THE
6 DEPARTMENT OF HUMAN SERVICES OR PRIMARY CONTRACTOR OF THE
7 DEPARTMENT OF HUMAN SERVICES TO MANAGE THE PURCHASE AND
8 PROVISION OF MEDICAL, BEHAVIORAL HEALTH OR HOME AND COMMUNITY-
9 BASED SERVICES.

10 "ANCILLARY SERVICE PLANS." ANY INDIVIDUAL OR GROUP HEALTH
11 INSURANCE PLAN, SUBSCRIBER CONTRACT OR CERTIFICATE THAT PROVIDES
12 EXCLUSIVE COVERAGE FOR DENTAL SERVICES OR VISION SERVICES. THE
13 TERM ALSO INCLUDES MEDICARE SUPPLEMENT POLICIES SUBJECT TO
14 SECTION 1882 OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C.
15 § 1395SS) AND THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE
16 UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT.

17 "APPLICABLE GOVERNMENTAL GUIDELINES." CLINICAL PRACTICE AND
18 ASSOCIATED GUIDELINES ISSUED UNDER THE AUTHORITY OF THE UNITED
19 STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES
20 FOOD AND DRUG ADMINISTRATION, CENTERS FOR DISEASE CONTROL AND
21 PREVENTION, PENNSYLVANIA DEPARTMENT OF HEALTH OR OTHER SIMILARLY
22 SITUATED FEDERAL OR STATE AGENCY, DEPARTMENT OR SUBUNIT THEREOF
23 FOCUSED ON THE PROVISION OR REGULATION OF MEDICAL CARE,
24 PRESCRIPTION DRUGS OR PUBLIC HEALTH WITHIN THE UNITED STATES.

25 "AUTHORIZED REPRESENTATIVE." ONE OF THE FOLLOWING:

26 (1) A PERSON, INCLUDING A HEALTH CARE PROVIDER, TO WHOM A
27 COVERED PERSON OR ENROLLEE HAS GIVEN EXPRESS WRITTEN CONSENT TO
28 REPRESENT THE COVERED PERSON OR ENROLLEE IN A COMPLAINT,
29 GRIEVANCE, ADVERSE BENEFIT DETERMINATION, INTERNAL APPEAL OR
30 EXTERNAL REVIEW PROCESS.

1 (2) A PERSON AUTHORIZED BY LAW TO PROVIDE SUBSTITUTED
2 CONSENT FOR A COVERED PERSON OR ENROLLEE.

3 (3) A FAMILY MEMBER OR TREATING HEALTH CARE PROVIDER
4 INVOLVED IN PROVIDING HEALTH CARE TO A COVERED PERSON OR
5 ENROLLEE IF THE COVERED PERSON OR ENROLLEE IS INCAPACITATED OR
6 UNAVAILABLE TO PROVIDE CONSENT DUE TO A MEDICAL EMERGENCY OR
7 NECESSARY TO PREVENT A SERIOUS AND IMMINENT THREAT TO THE HEALTH
8 OR SAFETY OF THE COVERED PERSON OR ENROLLEE.

9 "CLEAN CLAIM." A CLAIM FOR PAYMENT FOR A HEALTH CARE SERVICE
10 WHICH HAS NO DEFECT OR IMPROPRIETY. A DEFECT OR IMPROPRIETY
11 SHALL INCLUDE LACK OF REQUIRED SUBSTANTIATING DOCUMENTATION OR A
12 PARTICULAR CIRCUMSTANCE REQUIRING SPECIAL TREATMENT WHICH
13 PREVENTS TIMELY PAYMENT FROM BEING MADE ON THE CLAIM. THE TERM
14 SHALL NOT INCLUDE A CLAIM FROM A HEALTH CARE PROVIDER WHO IS
15 UNDER INVESTIGATION FOR FRAUD OR ABUSE REGARDING THAT CLAIM.

16 "CLINICAL REVIEW CRITERIA." THE SET OF WRITTEN SCREENING
17 PROCEDURES, DECISION ABSTRACTS, CLINICAL PROTOCOLS AND PRACTICE
18 GUIDELINES USED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN TO
19 DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE
20 SERVICES.

21 "CLOSELY-RELATED SERVICE." A HEALTH CARE SERVICE SUBJECT TO
22 PRIOR AUTHORIZATION THAT IS CLOSELY RELATED IN PURPOSE,
23 DIAGNOSTIC UTILITY OR DESIGNATED HEALTH CARE BILLING CODE, AND
24 PROVIDED ON THE SAME DATE OF SERVICE AS AN AUTHORIZED SERVICE,
25 SUCH THAT A PRUDENT HEALTH CARE PROVIDER, ACTING WITHIN THE
26 SCOPE OF THE PROVIDER'S LICENSE AND EXPERTISE, MAY REASONABLY BE
27 EXPECTED TO PERFORM THE SERVICE IN CONJUNCTION WITH OR IN LIEU
28 OF THE ORIGINALLY AUTHORIZED SERVICE IN RESPONSE TO MINOR
29 DIFFERENCES IN OBSERVED PATIENT CHARACTERISTICS OR NEEDS FOR
30 DIAGNOSTIC INFORMATION THAT WERE NOT READILY IDENTIFIABLE UNTIL

1 THE PROVIDER WAS ACTUALLY PERFORMING THE ORIGINALLY AUTHORIZED
2 SERVICE. THE TERM DOES NOT INCLUDE AN ORDER FOR OR
3 ADMINISTRATION OF A PRESCRIPTION DRUG OR ANY PART OF A SERIES OR
4 COURSE OF TREATMENTS.

5 "COMMISSIONER." THE INSURANCE COMMISSIONER OF THE
6 COMMONWEALTH.

7 "COMPLAINT." A DISPUTE OR OBJECTION REGARDING A
8 PARTICIPATING HEALTH CARE PROVIDER OR THE COVERAGE, OPERATIONS
9 OR MANAGEMENT POLICIES OF [A] AN INSURER OR MA OR CHIP MANAGED
10 CARE PLAN WHICH HAS NOT BEEN RESOLVED BY THE INSURER OR MA OR
11 CHIP MANAGED CARE PLAN AND HAS BEEN FILED WITH THE INSURER, MA
12 OR CHIP MANAGED CARE PLAN OR [WITH THE DEPARTMENT OF HEALTH OR
13 THE INSURANCE DEPARTMENT OF THE COMMONWEALTH] DEPARTMENT. THE
14 TERM DOES NOT INCLUDE A GRIEVANCE OR AN ADVERSE BENEFIT
15 DETERMINATION ELIGIBLE FOR EXTERNAL REVIEW.

16 "CONCURRENT [UTILIZATION] REVIEW." A REVIEW [BY A
17 UTILIZATION REVIEW ENTITY] PERFORMED BY AN INSURER OR MA OR CHIP
18 MANAGED CARE PLAN, OR BY A UTILIZATION REVIEW ENTITY ACTING ON
19 BEHALF OF AN INSURER OR MA OR CHIP MANAGED CARE PLAN OF ALL
20 REASONABLY NECESSARY SUPPORTING INFORMATION WHICH OCCURS DURING
21 AN ENROLLEE'S HOSPITAL STAY OR COURSE OF TREATMENT AND RESULTS
22 IN A DECISION TO APPROVE OR DENY PAYMENT FOR THE HEALTH CARE
23 SERVICE.

24 "COVERED BENEFIT." A HEALTH CARE SERVICE AS SET FORTH IN THE
25 TERMS OF A HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE
26 DEPARTMENT OF HUMAN SERVICES. THE TERM INCLUDES A COVERED
27 SERVICE.

28 "COVERED PERSON." A POLICYHOLDER, SUBSCRIBER OR OTHER
29 INDIVIDUAL WHO IS ENTITLED TO RECEIVE HEALTH CARE SERVICES UNDER
30 A HEALTH INSURANCE POLICY.

1 "COVERED SERVICE." A HEALTH CARE SERVICE ELIGIBLE FOR
2 PAYMENT UNDER THE TERMS OF A HEALTH INSURANCE POLICY OR AN
3 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

4 "DEPARTMENT." THE [DEPARTMENT OF HEALTH] INSURANCE
5 DEPARTMENT OF THE COMMONWEALTH.

6 "DISCHARGE PLANNING." THE FORMAL PROCESS FOR DETERMINING,
7 PRIOR TO DISCHARGE FROM A FACILITY, THE COORDINATION AND
8 MANAGEMENT OF CARE THAT A COVERED PERSON OR ENROLLEE WILL
9 RECEIVE FOLLOWING THE DISCHARGE.

10 "DRUG FORMULARY." A LISTING OF HEALTH INSURANCE POLICY OR MA
11 OR CHIP MANAGED CARE PLAN PREFERRED THERAPEUTIC DRUGS.

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

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

22 (2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

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

24 [EMERGENCY TRANSPORTATION AND RELATED EMERGENCY SERVICE PROVIDED
25 BY A LICENSED AMBULANCE SERVICE SHALL CONSTITUTE AN EMERGENCY
26 SERVICE.] THE TERM INCLUDES EMERGENCY TRANSPORTATION AND RELATED
27 EMERGENCY SERVICES PROVIDED BY A LICENSED AMBULANCE SERVICE.

28 "ENROLLEE." [ANY POLICYHOLDER, SUBSCRIBER, COVERED PERSON OR
29 OTHER INDIVIDUAL] AN INDIVIDUAL WHO IS ENTITLED TO RECEIVE
30 HEALTH CARE SERVICES UNDER [A MANAGED CARE PLAN] AN AGREEMENT

1 WITH THE DEPARTMENT OF HUMAN SERVICES.

2 "EVIDENCE-BASED STANDARD." INTERVENTIONS AND TREATMENT
3 APPROACHES THAT HAVE BEEN PROVEN EFFECTIVE THROUGH APPROPRIATE
4 EMPIRICAL ANALYSIS.

5 "FACILITY." A HEALTH CARE SETTING OR INSTITUTION PROVIDING
6 HEALTH CARE SERVICES, INCLUDING:

7 (1) A GENERAL, SPECIAL, PSYCHIATRIC OR REHABILITATION
8 HOSPITAL.

9 (2) AN AMBULATORY SURGICAL FACILITY.

10 (3) A CANCER TREATMENT CENTER.

11 (4) A BIRTH CENTER.

12 (5) A SKILLED NURSING CENTER.

13 (6) AN INPATIENT, OUTPATIENT OR RESIDENTIAL DRUG AND ALCOHOL
14 TREATMENT FACILITY.

15 (7) A LABORATORY, IMAGING, DIAGNOSTIC OR OTHER OUTPATIENT
16 MEDICAL SERVICE OR TESTING FACILITY.

17 (8) A HEALTH CARE PROVIDER OFFICE OR CLINIC.

18 "FINAL ADVERSE BENEFIT DETERMINATION." AN ADVERSE BENEFIT
19 DETERMINATION THAT HAS BEEN UPHELD BY AN INSURER OR A
20 UTILIZATION REVIEW ENTITY DESIGNATED BY THE INSURER AT THE
21 COMPLETION OF THE INSURER'S INTERNAL CLAIM AND APPEAL PROCEDURES
22 AS SPECIFIED IN SECTION 2161.1.

23 "GRIEVANCE." [AS PROVIDED IN SUBDIVISION (I), A] A REQUEST
24 TO AN MA OR CHIP MANAGED CARE PLAN BY AN ENROLLEE OR [A HEALTH
25 CARE PROVIDER, WITH THE WRITTEN CONSENT OF THE ENROLLEE,] AN
26 ENROLLEE'S AUTHORIZED REPRESENTATIVE TO HAVE [A] AN MA OR CHIP
27 MANAGED CARE PLAN [OR UTILIZATION REVIEW ENTITY] RECONSIDER A
28 DECISION SOLELY CONCERNING THE MEDICAL NECESSITY [AND],
29 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR
30 EFFECTIVENESS OF A HEALTH CARE SERVICE. IF THE MA OR CHIP

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 OR AN ADVERSE BENEFIT
DETERMINATION.

"HEALTH CARE PROVIDER." A LICENSED HOSPITAL OR HEALTH CARE
FACILITY, MEDICAL EQUIPMENT SUPPLIER OR PERSON WHO IS LICENSED,
CERTIFIED OR OTHERWISE REGULATED TO PROVIDE HEALTH CARE SERVICES
UNDER THE LAWS OF THIS COMMONWEALTH, INCLUDING A PHYSICIAN,
PODIATRIST, OPTOMETRIST, PSYCHOLOGIST, PHYSICAL THERAPIST,
CERTIFIED NURSE PRACTITIONER, REGISTERED NURSE, NURSE MIDWIFE,
PHYSICIAN'S ASSISTANT, CHIROPRACTOR, DENTIST, PHARMACIST OR AN
INDIVIDUAL ACCREDITED OR CERTIFIED TO PROVIDE BEHAVIORAL HEALTH
SERVICES. FOR MA OR CHIP MANAGED CARE PLANS, THE TERM SHALL ALSO
REFER TO AN INDIVIDUAL PROVIDING PERSONAL ASSISTANCE OR
REHABILITATIVE SERVICES.

"HEALTH CARE SERVICE." ANY COVERED TREATMENT, ADMISSION,
PROCEDURE, 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] A
COVERED PERSON OR ENROLLEE [UNDER A MANAGED CARE PLAN CONTRACT.]
FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE OR RELIEF OF A
HEALTH CONDITION, ILLNESS, INJURY, DISEASE OR FUNCTIONAL
LIMITATION UNDER THE TERMS OF EITHER A HEALTH INSURANCE POLICY

1 OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES. THE TERM
2 INCLUDES HOME-AND-COMMUNITY-BASED SERVICES PROVIDED TO AN
3 ENROLLEE UNDER THE TERMS OF AN AGREEMENT WITH THE DEPARTMENT OF
4 HUMAN SERVICES.

5 "HEALTH INSURANCE POLICY." A POLICY, SUBSCRIBER CONTRACT,
6 CERTIFICATE OR PLAN ISSUED BY AN INSURER THAT PROVIDES MEDICAL
7 OR HEALTH CARE COVERAGE. THE TERM DOES NOT INCLUDE ANY OF THE
8 FOLLOWING:

- 9 (1) AN ACCIDENT ONLY POLICY.
10 (2) A CREDIT ONLY POLICY.
11 (3) A LONG-TERM CARE OR DISABILITY INCOME POLICY.
12 (4) A SPECIFIED DISEASE POLICY.
13 (5) A MEDICARE SUPPLEMENT POLICY.
14 (6) A TRICARE POLICY, INCLUDING A CIVILIAN HEALTH AND
15 MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT
16 POLICY.
17 (7) A FIXED INDEMNITY POLICY.
18 (8) A HOSPITAL INDEMNITY POLICY.
19 (9) A DENTAL ONLY POLICY.
20 (10) A VISION ONLY POLICY.
21 (11) A WORKERS' COMPENSATION POLICY.
22 (12) AN AUTOMOBILE MEDICAL PAYMENT POLICY UNDER 75 PA.C.S.
23 (RELATING TO VEHICLES).
24 (13) A HOMEOWNER'S INSURANCE POLICY.
25 (14) ANY OTHER SIMILAR POLICIES PROVIDING FOR LIMITED
26 BENEFITS.

27 "INDEPENDENT REVIEW ORGANIZATION" OR "IRO." AN ENTITY
28 APPROVED BY THE DEPARTMENT UNDER SECTION 2161.10 THAT CONDUCTS
29 INDEPENDENT REVIEWS OF ADVERSE BENEFIT DETERMINATIONS, FINAL
30 ADVERSE BENEFIT DETERMINATIONS AND GRIEVANCES.

1 "INPATIENT ADMISSION." ADMISSION TO A FACILITY FOR PURPOSES
2 OF RECEIVING A HEALTH CARE SERVICE.

3 "INSURER." AN ENTITY LICENSED BY THE DEPARTMENT THAT OFFERS,
4 ISSUES OR RENEWS AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY
5 THAT IS OFFERED OR GOVERNED UNDER ANY OF THE FOLLOWING:

6 (1) THIS ACT, INCLUDING SECTION 630 AND ARTICLE XXIV.

7 (2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN
8 AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."

9 (3) 40 PA.C.S. CH. 61 (RELATING TO HEALTH PLAN CORPORATIONS)
10 OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN
11 CORPORATIONS).

12 THE TERM DOES NOT INCLUDE AN ENTITY OPERATING AS AN MA OR
13 CHIP MANAGED CARE PLAN.

14 ["MANAGED CARE PLAN." A HEALTH CARE PLAN THAT USES A
15 GATEKEEPER TO MANAGE THE UTILIZATION OF HEALTH CARE SERVICES,
16 INTEGRATES THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES TO
17 ENROLLEES BY ARRANGEMENTS WITH HEALTH CARE PROVIDERS SELECTED TO
18 PARTICIPATE ON THE BASIS OF SPECIFIC STANDARDS AND PROVIDES
19 FINANCIAL INCENTIVES FOR ENROLLEES TO USE THE PARTICIPATING
20 HEALTH CARE PROVIDERS IN ACCORDANCE WITH PROCEDURES ESTABLISHED
21 BY THE PLAN. A MANAGED CARE PLAN INCLUDES HEALTH CARE ARRANGED
22 THROUGH AN ENTITY OPERATING UNDER ANY OF THE FOLLOWING:

23 (1) SECTION 630.

24 (2) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN
25 AS THE "HEALTH MAINTENANCE ORGANIZATION ACT."

26 (3) THE ACT OF DECEMBER 14, 1992 (P.L.835, NO.134), KNOWN AS
27 THE "FRATERNAL BENEFIT SOCIETIES CODE."

28 (4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN
29 CORPORATIONS).

30 (5) 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL HEALTH

SERVICES PLAN CORPORATIONS) .

THE TERM INCLUDES AN ENTITY, INCLUDING A MUNICIPALITY,
WHETHER LICENSED OR UNLICENSED, THAT CONTRACTS WITH OR FUNCTIONS
AS A MANAGED CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO
ENROLLEES. THE TERM DOES NOT INCLUDE ANCILLARY SERVICE PLANS OR
AN INDEMNITY ARRANGEMENT WHICH IS PRIMARILY FEE FOR SERVICE.]

"MEDICAL ASSISTANCE OR CHILDREN'S HEALTH INSURANCE PROGRAM
MANAGED CARE PLAN" OR "MA OR CHIP MANAGED CARE PLAN." A HEALTH
CARE PLAN THAT USES A GATEKEEPER TO MANAGE THE UTILIZATION OF
HEALTH CARE SERVICES BY MEDICAL ASSISTANCE OR CHILDREN'S HEALTH
INSURANCE PROGRAM ENROLLEES AND INTEGRATES THE FINANCING AND
DELIVERY OF HEALTH CARE SERVICES TO ENROLLEES BY ARRANGEMENTS
WITH HEALTH CARE PROVIDERS SELECTED TO PARTICIPATE.

"MEDICAL OR SCIENTIFIC EVIDENCE." EVIDENCE FOUND IN ANY OF
THE FOLLOWING SOURCES:

(1) A PEER-REVIEWED SCIENTIFIC STUDY PUBLISHED IN OR
ACCEPTED FOR PUBLICATION BY A MEDICAL JOURNAL THAT MEETS
NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS
AND WHICH JOURNAL SUBMITS MOST OF ITS PUBLISHED ARTICLES FOR
REVIEW BY EXPERTS WHO ARE NOT PART OF THE JOURNAL'S EDITORIAL
STAFF.

(2) PEER-REVIEWED MEDICAL LITERATURE, INCLUDING LITERATURE
RELATING TO A THERAPY REVIEWED AND APPROVED BY A QUALIFIED
INSTITUTIONAL REVIEW BOARD, BIOMEDICAL COMPENDIA AND OTHER
MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL
INSTITUTES OF HEALTH'S LIBRARY OF MEDICINE FOR INDEXING IN INDEX
MEDICUS (MEDLINE) AND ELSEVIER SCIENCE LIMITED FOR INDEXING IN
EXCERPTA MEDICA (EMBASE) .

(3) A MEDICAL JOURNAL RECOGNIZED BY THE SECRETARY OF HEALTH
AND HUMAN SERVICES UNDER SECTION 1861(T)(2) OF THE SOCIAL

1 SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1395X(T)(2)).

2 (4) ONE OF THE FOLLOWING STANDARD REFERENCE COMPENDIA:

3 (I) THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG
4 INFORMATION.

5 (II) DRUGDEX INFORMATION SYSTEM.

6 (III) THE AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL
7 THERAPEUTICS.

8 (IV) THE UNITED STATES PHARMACOPOEIA-DRUG INFORMATION.

9 (5) FINDINGS, STUDIES OR RESEARCH CONDUCTED BY OR UNDER THE
10 AUSPICES OF A UNITED STATES GOVERNMENT AGENCY OR NATIONALLY
11 RECOGNIZED FEDERAL RESEARCH INSTITUTE, INCLUDING:

12 (I) THE UNITED STATES AGENCY FOR HEALTHCARE RESEARCH AND
13 QUALITY.

14 (II) THE NATIONAL INSTITUTES OF HEALTH.

15 (III) THE NATIONAL CANCER INSTITUTE.

16 (IV) THE NATIONAL ACADEMY OF SCIENCES.

17 (V) THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
18 SERVICES.

19 (VI) THE FOOD AND DRUG ADMINISTRATION.

20 (VII) ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL
21 INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL
22 VALUE OF HEALTH CARE SERVICES.

23 (6) OTHER MEDICAL OR SCIENTIFIC EVIDENCE THAT IS COMPARABLE
24 TO THE SOURCES SPECIFIED IN PARAGRAPHS (1), (2), (3), (4) AND
25 (5).

26 "MEDICAL POLICY." A WRITTEN DOCUMENT ADOPTED, MAINTAINED AND
27 APPLIED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN THAT
28 COMBINES THE CLINICAL REVIEW CRITERIA AND ANY ADDITIONAL
29 ADMINISTRATIVE REQUIREMENTS, AS APPLICABLE, NECESSARY TO
30 ARTICULATE THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S

1 STANDARDS FOR COVERAGE OF A GIVEN HEALTH CARE SERVICE OR SET OF
2 HEALTH CARE SERVICES UNDER THE TERMS OF A HEALTH INSURANCE
3 POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

4 "MEDICATION-ASSISTED TREATMENT." UNITED STATES FOOD AND DRUG
5 ADMINISTRATION-APPROVED PRESCRIPTION DRUGS USED IN COMBINATION
6 WITH COUNSELING AND BEHAVIORAL HEALTH THERAPIES AND MANAGEMENT
7 IN THE TREATMENT OF OPIOID USE DISORDERS.

8 "NAIC." THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

9 "NATIONALLY RECOGNIZED MEDICAL STANDARDS." CLINICAL
10 CRITERIA, PRACTICE GUIDELINES AND RELATED STANDARDS ESTABLISHED
11 BY NATIONAL QUALITY AND ACCREDITATION ENTITIES GENERALLY
12 RECOGNIZED IN THE UNITED STATES HEALTH CARE INDUSTRY.

13 "PARTICIPATING HEALTH CARE PROVIDER." A HEALTH CARE PROVIDER
14 THAT HAS ENTERED INTO A CONTRACTUAL OR OPERATING RELATIONSHIP
15 WITH AN INSURER OR MA OR CHIP MANAGED CARE PLAN TO PARTICIPATE
16 IN ONE OR MORE DESIGNATED NETWORKS OF THE INSURER AND TO PROVIDE
17 HEALTH CARE SERVICES TO COVERED PERSONS OR ENROLLEES UNDER THE
18 TERMS OF THE INSURER'S ADMINISTRATIVE POLICY OR AN AGREEMENT
19 WITH THE DEPARTMENT OF HUMAN SERVICES.

20 ["PLAN." A MANAGED CARE PLAN.]

21 "PRESCRIPTION DRUG." A DRUG OR BIOLOGICAL PRODUCT, AS BOTH
22 OF THOSE TERMS ARE DEFINED IN THE ACT OF NOVEMBER 24, 1976
23 (P.L.1163, NO.259), REFERRED TO AS THE GENERIC EQUIVALENT DRUG
24 LAW.

25 "PRIMARY CARE PROVIDER." A HEALTH CARE PROVIDER WHO, WITHIN
26 THE SCOPE OF THE PROVIDER'S PRACTICE, SUPERVISES, COORDINATES,
27 PRESCRIBES OR OTHERWISE PROVIDES OR PROPOSES TO PROVIDE HEALTH
28 CARE SERVICES TO [AN] A COVERED PERSON OR ENROLLEE, INITIATES
29 [ENROLLEE] A REFERRAL FOR SPECIALIST CARE AND MAINTAINS
30 CONTINUITY OF [ENROLLEE] CARE FOR THE COVERED PERSON OR

1 ENROLLEE.

2 "PRIMARY CONTRACTOR." A COUNTY, CONSORTIUM OF COUNTIES, MA
3 OR CHIP MANAGED CARE PLAN OR OTHER ENTITY THAT HAS AN AGREEMENT
4 WITH THE DEPARTMENT OF HUMAN SERVICES TO MANAGE THE PURCHASE AND
5 PROVISION OF BEHAVIOR HEALTH SERVICES.

6 "PRIOR AUTHORIZATION." A PROSPECTIVE UTILIZATION REVIEW
7 PERFORMED BY AN INSURER OR MA OR CHIP MANAGED CARE PLAN, OR BY A
8 UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF AN INSURER OR MA
9 OR CHIP MANAGED CARE PLAN, OF ALL REASONABLY NECESSARY
10 SUPPORTING INFORMATION THAT OCCURS PRIOR TO THE DELIVERY OR
11 PROVISION OF A HEALTH CARE SERVICE AND RESULTS IN A DECISION TO
12 APPROVE OR DENY PAYMENT FOR THE HEALTH CARE SERVICE. THE TERM
13 INCLUDES STEP THERAPY AND STEP THERAPY EXCEPTION REQUESTS.

14 "PRIOR AUTHORIZATION REQUEST." A REQUEST FOR PRIOR
15 AUTHORIZATION OF A HEALTH CARE SERVICE THAT MEETS AN INSURER'S
16 OR MA OR CHIP MANAGED CARE PLAN'S ADMINISTRATIVE POLICY
17 REQUIREMENTS FOR SUCH A REQUEST AND INCLUDES THE SPECIFIC
18 CLINICAL INFORMATION NECESSARY TO EVALUATE THE REQUEST UNDER THE
19 TERMS OF THE APPLICABLE MEDICAL POLICY.

20 ["PROSPECTIVE UTILIZATION REVIEW." A REVIEW BY A UTILIZATION
21 REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING INFORMATION
22 THAT OCCURS PRIOR TO THE DELIVERY OR PROVISION OF A HEALTH CARE
23 SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY PAYMENT FOR
24 THE HEALTH CARE SERVICE.]

25 "PROTECTED HEALTH INFORMATION." INFORMATION OR DATA, WHETHER
26 ORAL OR RECORDED IN ANY FORM OR MEDIUM, AND PERSONAL FACTS OR
27 INFORMATION ABOUT EVENTS OR RELATIONSHIPS THAT IDENTIFIES AN
28 INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION OR FOR WHICH
29 THERE IS A REASONABLE BASIS TO BELIEVE THAT THE INFORMATION
30 COULD BE USED TO IDENTIFY AN INDIVIDUAL, THAT RELATES TO ANY OF

1 THE FOLLOWING:

2 (1) THE PAST, PRESENT, OR FUTURE PHYSICAL, MENTAL OR
3 BEHAVIORAL HEALTH OR CONDITION OF AN INDIVIDUAL OR A MEMBER OF
4 THE INDIVIDUAL'S FAMILY.

5 (2) THE PROVISION OF HEALTH CARE SERVICES TO AN INDIVIDUAL.

6 (3) PAYMENT FOR THE PROVISION OF HEALTH CARE SERVICES TO AN
7 INDIVIDUAL.

8 "PROVIDER NETWORK." THE HEALTH CARE PROVIDERS DESIGNATED BY
9 [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN TO PROVIDE HEALTH
10 CARE SERVICES UNDER A HEALTH INSURANCE POLICY OR AN AGREEMENT
11 WITH THE DEPARTMENT OF HUMAN SERVICES.

12 "PROVIDER PORTAL." A DESIGNATED SECTION OR FUNCTIONAL
13 SOFTWARE MODULE ACCESSIBLE VIA AN INSURER'S OR MA OR CHIP
14 MANAGED CARE PLAN'S PUBLICLY ACCESSIBLE INTERNET WEBSITE THAT
15 FACILITATES HEALTH CARE PROVIDER SUBMISSION OF ELECTRONIC PRIOR
16 AUTHORIZATION REQUESTS.

17 "REFERRAL." A PRIOR AUTHORIZATION FROM [A] AN INSURER, MA OR
18 CHIP MANAGED CARE PLAN OR A PARTICIPATING HEALTH CARE PROVIDER
19 THAT ALLOWS [AN] A COVERED PERSON OR ENROLLEE TO HAVE ONE OR
20 MORE APPOINTMENTS WITH A HEALTH CARE PROVIDER FOR A HEALTH CARE
21 SERVICE.

22 "RETROSPECTIVE UTILIZATION REVIEW." [A REVIEW BY A
23 UTILIZATION REVIEW ENTITY OF ALL REASONABLY NECESSARY SUPPORTING
24 INFORMATION WHICH OCCURS FOLLOWING DELIVERY OR PROVISION OF A
25 HEALTH CARE SERVICE AND RESULTS IN A DECISION TO APPROVE OR DENY
26 PAYMENT FOR THE HEALTH CARE SERVICE.] REVIEW OF MEDICAL
27 NECESSITY PERFORMED BY AN INSURER OR MA OR CHIP MANAGED CARE
28 PLAN, OR BY A UTILIZATION REVIEW ENTITY ACTING ON BEHALF OF AN
29 INSURER OR MA OR CHIP MANAGED CARE PLAN AND CONDUCTED AFTER
30 HEALTH CARE SERVICES HAVE BEEN PROVIDED TO A COVERED PERSON OR

1 ENROLLEE, NOT INCLUDING THE REVIEW OF A CLAIM THAT IS LIMITED TO
2 AN EVALUATION OF THE REIMBURSEMENT LEVELS, VERACITY OF
3 DOCUMENTATION, ACCURACY OF CODING OR ADJUSTMENT FOR PAYMENT.

4 "SERVICE AREA." THE GEOGRAPHIC AREA FOR WHICH [THE] AN
5 INSURER OR MA OR CHIP MANAGED CARE PLAN IS LICENSED OR HAS BEEN
6 ISSUED A CERTIFICATE OF AUTHORITY.

7 "SPECIALIST." A HEALTH CARE PROVIDER WHOSE PRACTICE IS NOT
8 LIMITED TO PRIMARY HEALTH CARE SERVICES AND WHO HAS ADDITIONAL
9 POSTGRADUATE OR SPECIALIZED TRAINING, HAS BOARD CERTIFICATION OR
10 PRACTICES IN A LICENSED SPECIALIZED AREA OF HEALTH CARE. THE
11 TERM INCLUDES A HEALTH CARE PROVIDER WHO IS NOT CLASSIFIED BY
12 [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SOLELY AS A
13 PRIMARY CARE PROVIDER.

14 "STEP THERAPY." A COURSE OF TREATMENT IN WHICH CERTAIN
15 DESIGNATED DRUGS OR TREATMENT PROTOCOLS MUST BE EITHER
16 CONTRAINDICATED, OR USED AND FOUND TO BE INEFFECTIVE, PRIOR TO
17 APPROVAL OF COVERAGE OF OTHER DESIGNATED DRUGS OR TREATMENT
18 PROTOCOLS. THE TERM DOES NOT INCLUDE REQUESTS FOR COVERAGE OF
19 NONFORMULARY DRUGS.

20 "URGENT HEALTH CARE SERVICE." A COVERED HEALTH CARE SERVICE
21 SUBJECT TO PRIOR AUTHORIZATION THAT IS DELIVERED ON AN EXPEDITED
22 BASIS FOR THE TREATMENT OF AN ACUTE CONDITION WITH SYMPTOMS OF
23 SUFFICIENT SEVERITY PURSUANT TO A DETERMINATION BY A LICENSED
24 TREATING PHYSICIAN, OPERATING WITH THE INDIVIDUAL'S SCOPE OF
25 PRACTICE AND PROFESSIONAL EXPERTISE, THAT THE FAILURE TO PROVIDE
26 THE SERVICE IS LIKELY TO RESULT IN SERIOUS, LONG-TERM HEALTH
27 COMPLICATIONS OR A MATERIAL DETERIORATION IN THE COVERED
28 PERSON'S OR ENROLLEE'S CONDITION AND PROGNOSIS.

29 "URGENT REQUEST." A REQUEST FOR PRIOR AUTHORIZATION OF AN
30 URGENT HEALTHCARE SERVICE.

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

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

9 (2) A HEALTH CARE PROVIDER'S INTERNAL QUALITY ASSURANCE OR
10 UTILIZATION REVIEW PROCESS UNLESS THE REVIEW RESULTS IN DENIAL
11 OF PAYMENT FOR A HEALTH CARE SERVICE.] A SET OF FORMAL

12 TECHNIQUES DESIGNED TO MONITOR THE USE OF OR EVALUATE THE
13 MEDICAL NECESSITY, APPROPRIATENESS, EFFICACY OR EFFICIENCY OF
14 HEALTH CARE SERVICES, PROCEDURES OR SETTINGS, INCLUDING PRIOR
15 AUTHORIZATION, SECOND OPINION, CERTIFICATION, CONCURRENT REVIEW,
16 CASE MANAGEMENT, DISCHARGE PLANNING OR RETROSPECTIVE REVIEW, IN
17 ORDER TO MAKE A DETERMINATION REGARDING COVERAGE OF THE SERVICE
18 UNDER THE TERMS OF A HEALTH INSURANCE POLICY OR AN AGREEMENT
19 WITH THE DEPARTMENT OF HUMAN SERVICES.

20 "UTILIZATION REVIEW ENTITY." ANY ENTITY CERTIFIED PURSUANT
21 TO SUBDIVISION (H) THAT PERFORMS UTILIZATION REVIEW ON BEHALF OF
22 [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN.

23 (B) INSURER AND MA AND CHIP MANAGED CARE
24 PLAN REQUIREMENTS.

25 SECTION 2111. RESPONSIBILITIES OF INSURERS AND MA AND CHIP
26 MANAGED CARE PLANS.--[A] AN INSURER OR MA OR CHIP MANAGED CARE
27 PLAN SHALL DO ALL OF THE FOLLOWING:

28 (1) ASSURE AVAILABILITY AND ACCESSIBILITY OF ADEQUATE HEALTH
29 CARE PROVIDERS IN A TIMELY MANNER, WHICH ENABLES COVERED PERSONS
30 OR ENROLLEES TO HAVE ACCESS TO QUALITY CARE AND CONTINUITY OF

1 HEALTH CARE SERVICES.

2 (2) CONSULT WITH HEALTH CARE PROVIDERS IN ACTIVE CLINICAL
3 PRACTICE REGARDING PROFESSIONAL QUALIFICATIONS AND NECESSARY
4 SPECIALISTS TO BE INCLUDED IN [THE PLAN.] COVERAGE UNDER A
5 HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF
6 HUMAN SERVICES.

7 (3) ADOPT AND MAINTAIN A DEFINITION OF MEDICAL NECESSITY
8 USED BY [THE] AN INSURER OR MA OR CHIP MANAGED CARE PLAN IN
9 DETERMINING HEALTH CARE SERVICES.

10 (4) ENSURE THAT EMERGENCY SERVICES ARE PROVIDED TWENTY-FOUR
11 (24) HOURS A DAY, SEVEN (7) DAYS A WEEK AND PROVIDE REASONABLE
12 PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES.

13 (5) ADOPT AND MAINTAIN PROCEDURES BY WHICH [AN] A COVERED
14 PERSON OR ENROLLEE CAN OBTAIN HEALTH CARE SERVICES OUTSIDE THE
15 HEALTH INSURANCE POLICY'S OR MA OR CHIP MANAGED CARE PLAN'S
16 SERVICE AREA.

17 (6) ADOPT AND MAINTAIN PROCEDURES BY WHICH [AN] A COVERED
18 PERSON OR ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR
19 DISABLING DISEASE OR CONDITION SHALL, UPON REQUEST, RECEIVE AN
20 EVALUATION AND, IF THE HEALTH INSURANCE POLICY'S [PLAN'S]
21 ESTABLISHED STANDARDS ARE MET OR THE STANDARDS ESTABLISHED BY AN
22 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES, BE PERMITTED TO
23 RECEIVE:

24 (I) A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL
25 EXPERTISE IN TREATING THE DISEASE OR CONDITION; OR

26 (II) THE DESIGNATION OF A SPECIALIST TO PROVIDE AND
27 COORDINATE THE COVERED PERSON'S OR ENROLLEE'S PRIMARY AND
28 SPECIALTY CARE.

29 THE REFERRAL TO OR DESIGNATION OF A SPECIALIST SHALL BE PURSUANT
30 TO A TREATMENT PLAN APPROVED BY THE INSURER OR MA OR CHIP

1 MANAGED CARE PLAN IN CONSULTATION WITH THE PRIMARY CARE
2 PROVIDER, THE COVERED PERSON OR ENROLLEE AND, AS APPROPRIATE,
3 THE SPECIALIST. WHEN POSSIBLE, THE SPECIALIST MUST BE A HEALTH
4 CARE PROVIDER PARTICIPATING IN THE [PLAN.] HEALTH INSURANCE
5 POLICY OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER NETWORK.

6 (7) PROVIDE DIRECT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL
7 SERVICES BY PERMITTING [AN] A COVERED PERSON OR ENROLLEE TO
8 SELECT A HEALTH CARE PROVIDER PARTICIPATING IN THE [PLAN] HEALTH
9 INSURANCE POLICY OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER
10 NETWORK TO OBTAIN MATERNITY AND GYNECOLOGICAL CARE, INCLUDING
11 MEDICALLY NECESSARY AND APPROPRIATE FOLLOW-UP CARE AND REFERRALS
12 FOR DIAGNOSTIC TESTING RELATED TO MATERNITY AND GYNECOLOGICAL
13 CARE, WITHOUT PRIOR APPROVAL FROM A PRIMARY CARE PROVIDER. THE
14 HEALTH CARE SERVICES SHALL BE WITHIN THE SCOPE OF PRACTICE OF
15 THE SELECTED HEALTH CARE PROVIDER. THE SELECTED HEALTH CARE
16 PROVIDER SHALL INFORM THE COVERED PERSON'S OR ENROLLEE'S PRIMARY
17 CARE PROVIDER OF ALL HEALTH CARE SERVICES PROVIDED.

18 (8) ADOPT AND MAINTAIN A COMPLAINT PROCESS AS SET FORTH IN
19 SUBDIVISION (G).

20 (9) ADOPT AND MAINTAIN A GRIEVANCE PROCESS AS SET FORTH IN
21 SUBDIVISION (I).

22 (10) ADOPT AND MAINTAIN CREDENTIALING STANDARDS FOR HEALTH
23 CARE PROVIDERS AS SET FORTH IN SUBDIVISION (D).

24 (11) ENSURE THAT THERE ARE PARTICIPATING HEALTH CARE
25 PROVIDERS THAT ARE PHYSICALLY ACCESSIBLE TO PEOPLE WITH
26 DISABILITIES AND CAN COMMUNICATE WITH INDIVIDUALS WITH SENSORY
27 DISABILITIES IN ACCORDANCE WITH TITLE III OF THE AMERICANS WITH
28 DISABILITIES ACT OF 1990 (PUBLIC LAW 101-336, 42 U.S.C. § 12181
29 ET SEQ.).

30 (12) PROVIDE A LIST OF HEALTH CARE PROVIDERS PARTICIPATING

1 IN THE [PLAN] HEALTH INSURANCE POLICY OR MA OR CHIP MANAGED CARE
2 PLAN'S PROVIDER NETWORK TO THE DEPARTMENT EVERY TWO (2) YEARS OR
3 AS MAY OTHERWISE BE REQUIRED BY THE DEPARTMENT. THE LIST SHALL
4 INCLUDE THE EXTENT TO WHICH HEALTH CARE PROVIDERS IN THE [PLAN]
5 HEALTH INSURANCE POLICY OR MA OR CHIP MANAGED CARE PLAN'S
6 PROVIDER NETWORK ARE ACCEPTING NEW ENROLLEES.

7 (13) REPORT TO THE DEPARTMENT [AND THE INSURANCE DEPARTMENT]
8 IN ACCORDANCE WITH THE REQUIREMENTS OF THIS ARTICLE. SUCH
9 INFORMATION SHALL INCLUDE THE NUMBER, TYPE AND DISPOSITION OF
10 ALL COMPLAINTS [AND] GRIEVANCES [FILED WITH THE PLAN.] AND
11 ADVERSE BENEFIT DETERMINATIONS FILED WITH THE INSURER UNDER A
12 HEALTH INSURANCE POLICY OR WITH THE MA OR CHIP MANAGED CARE
13 PLAN, AS APPLICABLE.

14 SECTION 2112. FINANCIAL INCENTIVES PROHIBITION.--NO INSURER
15 OR MA OR CHIP MANAGED CARE PLAN [SHALL] MAY USE ANY FINANCIAL
16 INCENTIVE THAT COMPENSATES A HEALTH CARE PROVIDER FOR PROVIDING
17 LESS THAN MEDICALLY NECESSARY AND APPROPRIATE CARE TO [AN] A
18 COVERED PERSON OR ENROLLEE. NOTHING IN THIS SECTION SHALL BE
19 DEEMED TO PROHIBIT [A] AN INSURER OR MA OR CHIP MANAGED CARE
20 PLAN FROM USING A CAPITATED PAYMENT ARRANGEMENT OR OTHER RISK-
21 SHARING ARRANGEMENT.

22 SECTION 2113. MEDICAL GAG CLAUSE PROHIBITION.--(A) NO
23 INSURER OR MA OR CHIP MANAGED CARE PLAN MAY PENALIZE OR RESTRICT
24 A HEALTH CARE PROVIDER FROM DISCUSSING ANY OF THE FOLLOWING:

25 (1) [THE] THE PROCESS THAT THE INSURER OR MA OR CHIP MANAGED
26 CARE PLAN OR ANY ENTITY CONTRACTING WITH THE INSURER OR MA OR
27 CHIP MANAGED CARE PLAN USES OR PROPOSES TO USE TO DENY PAYMENT
28 FOR A HEALTH CARE SERVICE[;].

29 (2) [MEDICALLY] MEDICALLY NECESSARY AND APPROPRIATE CARE
30 WITH OR ON BEHALF OF [AN] A COVERED PERSON OR ENROLLEE,

1 INCLUDING INFORMATION REGARDING THE NATURE OF TREATMENT; RISKS
2 OF TREATMENT; ALTERNATIVE TREATMENTS; OR THE AVAILABILITY OF
3 ALTERNATE THERAPIES, CONSULTATION OR TESTS[; OR].

4 (3) [THE] THE DECISION OF [ANY] AN INSURER OR MA OR CHIP
5 MANAGED CARE PLAN TO DENY PAYMENT FOR A HEALTH CARE SERVICE.

6 (B) A PROVISION TO PROHIBIT OR RESTRICT DISCLOSURE OF
7 MEDICALLY NECESSARY AND APPROPRIATE HEALTH CARE INFORMATION
8 CONTAINED IN A CONTRACT WITH A HEALTH CARE PROVIDER IS CONTRARY
9 TO PUBLIC POLICY AND SHALL BE VOID AND UNENFORCEABLE.

10 (C) NO INSURER OR MA OR CHIP MANAGED CARE PLAN [SHALL] MAY
11 TERMINATE THE EMPLOYMENT OF OR A CONTRACT WITH A HEALTH CARE
12 PROVIDER FOR ANY OF THE FOLLOWING:

13 (1) ADVOCATING FOR MEDICALLY NECESSARY AND APPROPRIATE
14 HEALTH CARE CONSISTENT WITH THE DEGREE OF LEARNING AND SKILL
15 ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER
16 PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE.

17 (2) FILING A COMPLAINT, GRIEVANCE OR EXTERNAL REVIEW
18 PURSUANT TO THE PROCEDURES SET FORTH IN THIS ARTICLE.

19 (3) PROTESTING A DECISION, POLICY OR PRACTICE THAT THE
20 HEALTH CARE PROVIDER, CONSISTENT WITH THE DEGREE OF LEARNING AND
21 SKILL ORDINARILY POSSESSED BY A REPUTABLE HEALTH CARE PROVIDER
22 PRACTICING ACCORDING TO THE APPLICABLE LEGAL STANDARD OF CARE,
23 REASONABLY BELIEVES INTERFERES WITH THE HEALTH CARE PROVIDER'S
24 ABILITY TO PROVIDE MEDICALLY NECESSARY AND APPROPRIATE HEALTH
25 CARE.

26 (D) NOTHING IN THIS SECTION SHALL:

27 (1) PROHIBIT [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN
28 FROM MAKING A DETERMINATION NOT TO PAY FOR A PARTICULAR MEDICAL
29 TREATMENT, SUPPLY OR SERVICE, ENFORCING REASONABLE PEER REVIEW
30 OR UTILIZATION REVIEW PROTOCOLS OR MAKING A DETERMINATION THAT A

1 HEALTH CARE PROVIDER HAS OR HAS NOT COMPLIED WITH APPROPRIATE
2 PROTOCOLS.

3 (2) BE CONSTRUED AS REQUIRING [A] AN INSURER OR MA OR CHIP
4 MANAGED CARE PLAN TO PROVIDE, REIMBURSE FOR OR COVER COUNSELING,
5 REFERRAL OR OTHER HEALTH CARE SERVICES IF THE INSURER OR MA OR
6 CHIP MANAGED CARE PLAN:

7 (I) OBJECTS TO THE PROVISION OF THAT SERVICE ON MORAL OR
8 RELIGIOUS GROUNDS; AND

9 (II) MAKES AVAILABLE INFORMATION ON ITS POLICIES REGARDING
10 SUCH HEALTH CARE SERVICES TO COVERED PERSON OR ENROLLEES AND
11 PROSPECTIVE COVERED PERSON OR ENROLLEES.

12 SECTION 2116. EMERGENCY SERVICES.--(A) IF [AN] A COVERED
13 PERSON OR ENROLLEE SEEKS EMERGENCY SERVICES AND THE EMERGENCY
14 HEALTH CARE PROVIDER DETERMINES THAT EMERGENCY SERVICES ARE
15 NECESSARY, THE EMERGENCY HEALTH CARE PROVIDER SHALL INITIATE
16 NECESSARY INTERVENTION TO EVALUATE AND, IF NECESSARY, STABILIZE
17 THE CONDITION OF THE COVERED PERSON OR ENROLLEE WITHOUT SEEKING
18 OR RECEIVING AUTHORIZATION FROM THE INSURER OR MA OR CHIP
19 MANAGED CARE PLAN. THE INSURER OR MA OR CHIP MANAGED CARE PLAN
20 MAY NOT REQUIRE A HEALTH CARE PROVIDER TO SUBMIT A REQUEST FOR
21 PRIOR AUTHORIZATION FOR AN EMERGENCY SERVICE. THE INSURER OR MA
22 OR CHIP MANAGED CARE PLAN SHALL PAY ALL REASONABLY NECESSARY
23 COSTS ASSOCIATED WITH EMERGENCY SERVICES PROVIDED DURING THE
24 PERIOD OF EMERGENCY, SUBJECT TO ALL COPAYMENTS, COINSURANCES OR
25 DEDUCTIBLES. WHEN PROCESSING A REIMBURSEMENT CLAIM FOR EMERGENCY
26 SERVICES, [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
27 CONSIDER BOTH THE PRESENTING SYMPTOMS AND THE SERVICES PROVIDED.
28 (A.1) THE EMERGENCY HEALTH CARE PROVIDER SHALL NOTIFY THE
29 COVERED PERSON'S INSURER OR ENROLLEE'S MA OR CHIP MANAGED CARE
30 PLAN OF THE PROVISION OF EMERGENCY SERVICES AND THE CONDITION OF

1 THE COVERED PERSON OR ENROLLEE.

2 (1) THE HEALTH CARE PROVIDER SHALL NOTIFY A COVERED PERSON'S
3 INSURER OF THE PROVISION OF EMERGENCY SERVICES AND THE CONDITION
4 OF THE COVERED PERSON WITHIN TWO BUSINESS DAYS FOLLOWING THE
5 PERIOD OF EMERGENCY.

6 (2) THE HEALTH CARE PROVIDER SHALL NOTIFY THE ENROLLEE'S MA
7 OR CHIP MANAGED CARE PLAN OF THE PROVISION OF EMERGENCY SERVICES
8 AND THE CONDITION OF THE ENROLLEE WITHIN TEN DAYS FOLLOWING THE
9 PERIOD OF EMERGENCY.

10 (A.2) IF [AN] A COVERED PERSON'S OR ENROLLEE'S CONDITION HAS
11 STABILIZED AND THE COVERED PERSON OR ENROLLEE CAN BE TRANSPORTED
12 WITHOUT SUFFERING DETRIMENTAL CONSEQUENCES OR AGGRAVATING THE
13 COVERED PERSON'S OR ENROLLEE'S CONDITION, THE COVERED PERSON OR
14 ENROLLEE MAY BE RELOCATED TO ANOTHER FACILITY TO RECEIVE
15 CONTINUED CARE AND TREATMENT AS NECESSARY.

16 (B) FOR EMERGENCY SERVICES RENDERED BY A LICENSED EMERGENCY
17 MEDICAL SERVICES AGENCY, AS DEFINED IN 35 PA.C.S. § 8103
18 (RELATING TO DEFINITIONS), THAT HAS THE ABILITY TO TRANSPORT
19 PATIENTS OR IS PROVIDING AND BILLING FOR EMERGENCY SERVICES
20 UNDER AN AGREEMENT WITH AN EMERGENCY MEDICAL SERVICES AGENCY
21 THAT HAS THAT ABILITY, THE INSURER OR MA OR CHIP MANAGED CARE
22 PLAN MAY NOT DENY A CLAIM FOR PAYMENT SOLELY BECAUSE THE
23 ENROLLEE DID NOT REQUIRE TRANSPORT OR REFUSED TO BE TRANSPORTED.

24 (C) FOR EMERGENCY SERVICES PROVIDED TO [MEDICAL ASSISTANCE
25 PARTICIPANTS] MA OR CHIP MANAGED CARE PLAN ENROLLEES, THE
26 FOLLOWING PROVISIONS SHALL APPLY:

27 (1) THE PROVISIONS OF SUBSECTION (B) SHALL APPLY TO THE SAME
28 SERVICES PROVIDED TO MEDICAL ASSISTANCE PARTICIPANTS UNDER
29 ARTICLE IV OF THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS
30 THE HUMAN SERVICES CODE.

1 (2) PAYMENT FOR THE SERVICES SHALL BE IN ACCORDANCE WITH THE
2 CURRENT MA OR CHIP MANAGED CARE CONTRACTED RATES.

3 (3) SUFFICIENT FUNDS SHALL BE APPROPRIATED EACH FISCAL YEAR
4 FOR PAYMENT OF THE SERVICES.

5 [(D) THE PROVISIONS OF SUBSECTION (B) SHALL APPLY TO ALL
6 GROUP AND INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE POLICIES
7 ISSUED BY A LICENSED HEALTH INSURER.]

8 SECTION 2117. CONTINUITY OF CARE.--(A) EXCEPT AS PROVIDED
9 UNDER SUBSECTION (B), IF [A] AN INSURER OR MA OR CHIP MANAGED
10 CARE PLAN INITIATES TERMINATION OF ITS CONTRACT WITH A
11 PARTICIPATING HEALTH CARE PROVIDER, [AN] A COVERED PERSON OR
12 ENROLLEE MAY CONTINUE AN ONGOING COURSE OF TREATMENT WITH THAT
13 HEALTH CARE PROVIDER AT THE COVERED PERSON'S OR ENROLLEE'S
14 OPTION FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM
15 THE DATE THE COVERED PERSON OR ENROLLEE WAS NOTIFIED BY THE
16 INSURER OR MA OR CHIP MANAGED CARE PLAN OF THE TERMINATION OR
17 PENDING TERMINATION. THE INSURER OR MA OR CHIP MANAGED CARE
18 PLAN, IN CONSULTATION WITH THE COVERED PERSON OR ENROLLEE AND
19 THE HEALTH CARE PROVIDER, MAY EXTEND THE TRANSITIONAL PERIOD IF
20 DETERMINED TO BE CLINICALLY APPROPRIATE. IN THE CASE OF [AN] A
21 COVERED PERSON OR ENROLLEE IN THE SECOND OR THIRD TRIMESTER OF
22 PREGNANCY AT THE TIME OF NOTICE OF THE TERMINATION OR PENDING
23 TERMINATION, THE TRANSITIONAL PERIOD SHALL EXTEND THROUGH
24 POSTPARTUM CARE RELATED TO THE DELIVERY. ANY HEALTH CARE SERVICE
25 PROVIDED UNDER THIS SECTION SHALL BE COVERED BY THE INSURER OR
26 MA OR CHIP MANAGED CARE PLAN UNDER THE SAME TERMS AND CONDITIONS
27 AS APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

28 (B) IF [THE] AN INSURER OR MA OR CHIP MANAGED CARE PLAN
29 TERMINATES THE CONTRACT OF A PARTICIPATING HEALTH CARE PROVIDER
30 FOR CAUSE, INCLUDING BREACH OF CONTRACT, FRAUD, CRIMINAL

1 ACTIVITY OR POSING A DANGER TO [AN] A COVERED PERSON OR ENROLLEE
2 OR THE HEALTH, SAFETY OR WELFARE OF THE PUBLIC AS DETERMINED BY
3 THE INSURER OR MA OR CHIP MANAGED CARE PLAN, THE INSURER OR MA
4 OR CHIP MANAGED CARE PLAN SHALL NOT BE RESPONSIBLE FOR HEALTH
5 CARE SERVICES PROVIDED TO THE COVERED PERSON OR ENROLLEE
6 FOLLOWING THE DATE OF TERMINATION.

7 (C) IF [THE] AN INSURER OR MA OR CHIP MANAGED CARE PLAN
8 TERMINATES THE CONTRACT OF A PARTICIPATING PRIMARY CARE
9 PROVIDER, THE INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
10 NOTIFY EVERY COVERED PERSON OR ENROLLEE SERVED BY THAT PROVIDER
11 OF THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S TERMINATION
12 OF ITS CONTRACT AND SHALL REQUEST THAT THE COVERED PERSON OR
13 ENROLLEE SELECT ANOTHER PRIMARY CARE PROVIDER.

14 (D) A NEW COVERED PERSON OR ENROLLEE MAY CONTINUE AN ONGOING
15 COURSE OF TREATMENT WITH A NONPARTICIPATING HEALTH CARE PROVIDER
16 FOR A TRANSITIONAL PERIOD OF UP TO SIXTY (60) DAYS FROM THE
17 EFFECTIVE DATE OF ENROLLMENT IN A HEALTH INSURANCE POLICY OR MA
18 OR CHIP MANAGED CARE PLAN. THE INSURER OR MA OR CHIP MANAGED
19 CARE PLAN, IN CONSULTATION WITH THE COVERED PERSON OR ENROLLEE
20 AND THE HEALTH CARE PROVIDER, MAY EXTEND THIS TRANSITIONAL
21 PERIOD IF DETERMINED TO BE CLINICALLY APPROPRIATE. IN THE CASE
22 OF A NEW COVERED PERSON OR ENROLLEE IN THE SECOND OR THIRD
23 TRIMESTER OF PREGNANCY ON THE EFFECTIVE DATE OF ENROLLMENT, THE
24 TRANSITIONAL PERIOD SHALL EXTEND THROUGH POSTPARTUM CARE RELATED
25 TO THE DELIVERY. ANY HEALTH CARE SERVICE PROVIDED UNDER THIS
26 SECTION SHALL BE COVERED BY THE HEALTH INSURANCE POLICY OR MA OR
27 CHIP MANAGED CARE PLAN UNDER THE SAME TERMS AND CONDITIONS AS
28 APPLICABLE FOR PARTICIPATING HEALTH CARE PROVIDERS.

29 (E) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN MAY
30 REQUIRE A NONPARTICIPATING HEALTH CARE PROVIDER WHOSE HEALTH

CARE SERVICES ARE COVERED UNDER THIS SECTION TO MEET THE SAME
TERMS AND CONDITIONS AS A PARTICIPATING HEALTH CARE PROVIDER.

(F) NOTHING IN THIS SECTION SHALL REQUIRE [A] AN INSURER OR
MA OR CHIP MANAGED CARE PLAN TO PROVIDE HEALTH CARE SERVICES
THAT ARE NOT OTHERWISE COVERED UNDER THE TERMS AND CONDITIONS OF
THE [PLAN] COVERED PERSON'S HEALTH INSURANCE POLICY OR AN
AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

SECTION 2121. CREDENTIALING PROCEDURES.-- (A) [A] AN INSURER
OR MA OR CHIP MANAGED CARE PLAN SHALL ESTABLISH A CREDENTIALING
PROCESS TO ENROLL QUALIFIED HEALTH CARE PROVIDERS AND CREATE AN
ADEQUATE PROVIDER NETWORK. [THE PROCESS SHALL BE APPROVED BY THE
DEPARTMENT AND SHALL INCLUDE WRITTEN CRITERIA AND PROCEDURES FOR
INITIAL ENROLLMENT, RENEWAL, RESTRICTIONS AND TERMINATION OF
CREDENTIALS FOR HEALTH CARE PROVIDERS.]

(A.1) AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
CREDENTIALING PROCESS SHALL BE SUBJECT TO APPROVAL BY THE
DEPARTMENT AND SHALL INCLUDE WRITTEN CRITERIA AND PROCEDURES FOR
AT LEAST THE FOLLOWING:

(1) INITIAL CREDENTIALING.

(2) RENEWAL OF CREDENTIALING.

(3) RESTRICTING AND TERMINATING THE CREDENTIALS FOR HEALTH
CARE PROVIDERS.

(B) THE DEPARTMENT SHALL ESTABLISH CREDENTIALING STANDARDS
FOR INSURERS AND MA OR CHIP MANAGED CARE PLANS. THE DEPARTMENT
MAY ADOPT NATIONALLY RECOGNIZED ACCREDITING STANDARDS TO
ESTABLISH THE CREDENTIALING STANDARDS FOR INSURERS AND MA OR
CHIP MANAGED CARE PLANS.

(C) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
SUBMIT A REPORT TO THE DEPARTMENT REGARDING ITS CREDENTIALING
PROCESS AT LEAST EVERY TWO (2) YEARS OR AS MAY OTHERWISE BE

1 REQUIRED BY THE DEPARTMENT.

2 (D) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
3 DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES TO
4 HEALTH CARE PROVIDERS THAT APPLY TO PARTICIPATE OR THAT ARE
5 PARTICIPATING IN THE INSURER'S OR MANAGED CARE PLAN'S PROVIDER
6 NETWORK. [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
7 ALSO DISCLOSE RELEVANT CREDENTIALING CRITERIA AND PROCEDURES
8 PURSUANT TO A COURT ORDER OR RULE. ANY INDIVIDUAL PROVIDING
9 INFORMATION DURING THE CREDENTIALING PROCESS OF [A] AN INSURER
10 OR MA OR CHIP MANAGED CARE PLAN SHALL HAVE THE PROTECTIONS SET
11 FORTH IN THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS
12 THE "PEER REVIEW PROTECTION ACT."

13 (E) NO INSURER OR MA OR CHIP MANAGED CARE PLAN [~~SHALL~~] MAY
14 EXCLUDE OR TERMINATE A HEALTH CARE PROVIDER FROM PARTICIPATION
15 IN THE [~~PLAN~~] INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
16 PROVIDER NETWORK DUE TO ANY OF THE FOLLOWING:

17 (1) THE HEALTH CARE PROVIDER ENGAGED IN ANY OF THE
18 ACTIVITIES SET FORTH IN SECTION 2113(C).

19 (2) THE HEALTH CARE PROVIDER HAS A PRACTICE THAT INCLUDES A
20 SUBSTANTIAL NUMBER OF PATIENTS WITH EXPENSIVE MEDICAL
21 CONDITIONS.

22 (3) THE HEALTH CARE PROVIDER OBJECTS TO THE PROVISION OF OR
23 REFUSES TO PROVIDE A HEALTH CARE SERVICE ON MORAL OR RELIGIOUS
24 GROUNDS.

25 (F) IF [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN DENIES
26 ENROLLMENT OR RENEWAL OF CREDENTIALS TO A HEALTH CARE PROVIDER,
27 THE INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL PROVIDE THE
28 HEALTH CARE PROVIDER WITH WRITTEN NOTICE OF THE DECISION. THE
29 NOTICE SHALL INCLUDE A CLEAR RATIONALE FOR THE DECISION.

30 SECTION 2131. CONFIDENTIALITY.--(A) [A] AN INSURER OR MA OR

1 CHIP MANAGED CARE PLAN [AND A UTILIZATION REVIEW ENTITY] SHALL
2 ADOPT AND MAINTAIN PROCEDURES TO ENSURE THAT ALL [IDENTIFIABLE]
3 PROTECTED HEALTH INFORMATION REGARDING COVERED PERSON OR
4 ENROLLEE HEALTH, DIAGNOSIS AND TREATMENT IS ADEQUATELY PROTECTED
5 AND REMAINS CONFIDENTIAL IN COMPLIANCE WITH ALL APPLICABLE
6 FEDERAL AND STATE LAWS AND REGULATIONS AND PROFESSIONAL ETHICAL
7 STANDARDS.

8 (B) TO THE EXTENT [A] AN INSURER OR MA OR CHIP MANAGED CARE
9 PLAN MAINTAINS MEDICAL RECORDS, THE INSURER OR MA OR CHIP
10 MANAGED CARE PLAN SHALL ADOPT AND MAINTAIN PROCEDURES TO ENSURE
11 THAT COVERED PERSONS AND ENROLLEES HAVE TIMELY ACCESS TO THEIR
12 MEDICAL RECORDS, INCLUDING MEDICAL RECORDS PROVIDED BY A HEALTH
13 CARE PROVIDER IN THE CONTEXT OF UTILIZATION REVIEW OR A
14 COMPLAINT, GRIEVANCE OR ADVERSE BENEFIT DETERMINATION, UNLESS
15 PROHIBITED BY FEDERAL OR STATE LAW OR REGULATION.

16 (C) (1) INFORMATION REGARDING [AN] A COVERED PERSON'S OR
17 ENROLLEE'S HEALTH OR TREATMENT SHALL BE AVAILABLE TO THE COVERED
18 PERSON OR ENROLLEE, THE COVERED PERSON'S OR ENROLLEE'S
19 [DESIGNEE] AUTHORIZED REPRESENTATIVE OR AS NECESSARY TO PREVENT
20 DEATH OR SERIOUS INJURY.

21 (2) NOTHING IN THIS SECTION SHALL:

22 (I) PREVENT DISCLOSURE NECESSARY TO DETERMINE COVERAGE,
23 REVIEW COMPLAINTS [OR] GRIEVANCES OR ADVERSE BENEFIT
24 DETERMINATIONS, CONDUCT UTILIZATION REVIEW OR FACILITATE PAYMENT
25 OF A CLAIM.

26 (II) DENY THE DEPARTMENT[, THE INSURANCE DEPARTMENT] OR THE
27 DEPARTMENT OF [PUBLIC WELFARE] HUMAN SERVICES ACCESS TO RECORDS
28 FOR PURPOSES OF QUALITY ASSURANCE, INVESTIGATION OF COMPLAINTS
29 [OR] GRIEVANCES OR ADVERSE BENEFIT DETERMINATIONS, ENFORCEMENT
30 OR OTHER ACTIVITIES RELATED TO COMPLIANCE WITH THIS ARTICLE AND

1 OTHER LAWS OF THIS COMMONWEALTH. RECORDS SHALL BE ACCESSIBLE
2 ONLY TO DEPARTMENT EMPLOYEES OR AGENTS WITH DIRECT
3 RESPONSIBILITIES UNDER THE PROVISIONS OF THIS SUBPARAGRAPH.

4 (III) DENY ACCESS TO INFORMATION NECESSARY FOR A UTILIZATION
5 REVIEW ENTITY TO CONDUCT A REVIEW UNDER THIS ARTICLE.

6 (IV) DENY ACCESS TO THE INSURER OR MA OR CHIP MANAGED CARE
7 PLAN FOR INTERNAL QUALITY REVIEW, INCLUDING REVIEWS CONDUCTED AS
8 PART OF THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S QUALITY
9 OVERSIGHT PROCESS. DURING SUCH REVIEWS, COVERED PERSONS AND
10 ENROLLEES SHALL REMAIN ANONYMOUS TO THE GREATEST EXTENT
11 POSSIBLE.

12 (V) DENY ACCESS TO INSURERS OR MA OR CHIP MANAGED CARE
13 PLANS, HEALTH CARE PROVIDERS AND THEIR RESPECTIVE DESIGNEES FOR
14 THE PURPOSE OF PROVIDING PATIENT CARE MANAGEMENT, OUTCOMES
15 IMPROVEMENT AND RESEARCH. FOR THIS PURPOSE, COVERED PERSONS AND
16 ENROLLEES SHALL PROVIDE CONSENT AND SHALL REMAIN ANONYMOUS TO
17 THE GREATEST EXTENT POSSIBLE.

18 (F) INFORMATION FOR COVERED
19 PERSONS AND ENROLLEES.

20 SECTION 2136. REQUIRED DISCLOSURE.--(A) [A] AN INSURER OR
21 MA OR CHIP MANAGED CARE PLAN SHALL SUPPLY EACH COVERED PERSON OR
22 ENROLLEE AND, UPON WRITTEN REQUEST, EACH PROSPECTIVE COVERED
23 PERSON OR ENROLLEE OR HEALTH CARE PROVIDER WITH THE FOLLOWING
24 WRITTEN INFORMATION. SUCH INFORMATION SHALL BE EASILY
25 UNDERSTANDABLE BY THE LAYPERSON AND SHALL INCLUDE, BUT NOT BE
26 LIMITED TO:

27 (1) A DESCRIPTION OF COVERAGE, BENEFITS AND BENEFIT
28 MAXIMUMS, INCLUDING BENEFIT LIMITATIONS AND EXCLUSIONS OF
29 COVERAGE, HEALTH CARE SERVICES AND THE DEFINITION OF MEDICAL
30 NECESSITY USED BY THE INSURER OR MA OR CHIP MANAGED CARE PLAN IN

1 DETERMINING WHETHER THESE BENEFITS WILL BE COVERED. THE
2 FOLLOWING STATEMENT OR SUBSTANTIALLY SIMILAR STATEMENT SHALL BE
3 INCLUDED IN ALL MARKETING MATERIALS IN BOLDFACE TYPE:

4 FOR INSURERS: THIS [MANAGED CARE PLAN] HEALTH INSURANCE
5 POLICY MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES. READ YOUR
6 CONTRACT OR MEMBER HANDBOOK CAREFULLY TO DETERMINE WHICH
7 HEALTH CARE SERVICES ARE COVERED.

8 FOR MA OR CHIP MANAGED CARE PLANS: YOUR MANAGED CARE PLAN MAY
9 NOT COVER ALL YOUR HEALTH CARE EXPENSES. READ YOUR MEMBER
10 HANDBOOK CAREFULLY TO DETERMINE WHICH HEALTH CARE SERVICES
11 ARE COVERED.

12 THE NOTICE SHALL BE FOLLOWED BY A TELEPHONE NUMBER TO CONTACT
13 THE INSURER OR MA OR CHIP MANAGED CARE PLAN.

14 (2) A DESCRIPTION OF ALL NECESSARY PRIOR AUTHORIZATIONS OR
15 OTHER REQUIREMENTS FOR NONEMERGENCY HEALTH CARE SERVICES AS
16 REQUIRED BY SECTION 2155.

17 (3) AN EXPLANATION OF [AN] A COVERED PERSON'S OR ENROLLEE'S
18 FINANCIAL RESPONSIBILITY FOR PAYMENT OF PREMIUMS, COINSURANCE,
19 COPAYMENTS, DEDUCTIBLES AND OTHER CHARGES, ANNUAL LIMITS ON [AN]
20 A COVERED PERSON'S OR ENROLLEE'S FINANCIAL RESPONSIBILITY AND
21 CAPS ON PAYMENTS FOR HEALTH CARE SERVICES PROVIDED UNDER THE
22 [PLAN] HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE
23 DEPARTMENT OF HUMAN SERVICES.

24 (4) AN EXPLANATION OF [AN] A COVERED PERSON'S OR ENROLLEE'S
25 FINANCIAL RESPONSIBILITY FOR PAYMENT WHEN A HEALTH CARE SERVICE
26 IS PROVIDED BY A NONPARTICIPATING HEALTH CARE PROVIDER, WHEN A
27 HEALTH CARE SERVICE IS PROVIDED BY ANY HEALTH CARE PROVIDER
28 WITHOUT REQUIRED AUTHORIZATION OR WHEN THE CARE RENDERED IS NOT
29 COVERED [BY THE PLAN] UNDER THE HEALTH INSURANCE POLICY OR BY AN
30 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.

1 (5) A DESCRIPTION OF HOW THE INSURER OR MA OR CHIP MANAGED
2 CARE PLAN ADDRESSES THE NEEDS OF NON-ENGLISH-SPEAKING COVERED
3 PERSONS OR ENROLLEES.

4 (6) A NOTICE OF MAILING ADDRESSES AND TELEPHONE NUMBERS
5 NECESSARY TO ENABLE [AN] A COVERED PERSON OR ENROLLEE TO OBTAIN
6 APPROVAL OR AUTHORIZATION OF A HEALTH CARE SERVICE OR OTHER
7 INFORMATION REGARDING THE HEALTH INSURANCE POLICY OR SERVICES
8 COVERED BY THE MA OR CHIP MANAGED CARE PLAN.

9 (7) A SUMMARY OF THE INSURER'S OR MA OR CHIP MANAGED CARE
10 PLAN'S UTILIZATION REVIEW POLICIES AND PROCEDURES.

11 (8) A SUMMARY OF ALL COMPLAINT [AND] GRIEVANCE OR ADVERSE
12 BENEFIT DETERMINATION PROCEDURES USED TO RESOLVE DISPUTES
13 BETWEEN THE INSURER OR MA OR CHIP MANAGED CARE PLAN AND [AN] A
14 COVERED PERSON OR ENROLLEE OR A HEALTH CARE PROVIDER, INCLUDING:

15 (I) THE PROCEDURE TO FILE A COMPLAINT [OR] GRIEVANCE OR
16 ADVERSE BENEFIT DETERMINATION APPEAL AS SET FORTH IN THIS
17 ARTICLE, INCLUDING A TOLL-FREE TELEPHONE NUMBER TO OBTAIN
18 INFORMATION REGARDING THE FILING AND STATUS OF A COMPLAINT [OR] GRIEVANCE
19 OR ADVERSE BENEFIT DETERMINATION.

20 (II) THE RIGHT TO APPEAL A DECISION RELATING TO A COMPLAINT
21 [OR] GRIEVANCE OR ADVERSE BENEFIT DETERMINATION.

22 (III) THE COVERED PERSON'S OR ENROLLEE'S RIGHT TO DESIGNATE
23 A REPRESENTATIVE TO PARTICIPATE IN THE COMPLAINT [OR] GRIEVANCE
24 OR ADVERSE BENEFIT DETERMINATION PROCESS AS SET FORTH IN THIS
25 ARTICLE.

26 (IV) A NOTICE THAT ALL [DISPUTES] DECISIONS INVOLVING DENIAL
27 OF PAYMENT FOR A HEALTH CARE SERVICE WILL BE MADE BY QUALIFIED
28 PERSONNEL WITH EXPERIENCE IN THE SAME OR SIMILAR SCOPE OF
29 PRACTICE AND THAT ALL NOTICES OF DECISIONS WILL INCLUDE
30 INFORMATION REGARDING THE BASIS FOR THE DETERMINATION.

(9) A DESCRIPTION OF THE PROCEDURE FOR PROVIDING EMERGENCY SERVICES TWENTY-FOUR (24) HOURS A DAY. THE DESCRIPTION SHALL INCLUDE:

(I) A DEFINITION OF EMERGENCY SERVICES AS SET FORTH IN THIS ARTICLE.

(II) NOTICE THAT EMERGENCY SERVICES ARE NOT SUBJECT TO PRIOR APPROVAL.

(III) THE COVERED PERSON'S OR ENROLLEE'S FINANCIAL AND OTHER RESPONSIBILITIES REGARDING EMERGENCY SERVICES, INCLUDING THE RECEIPT OF THESE SERVICES OUTSIDE THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S SERVICE AREA.

(10) A DESCRIPTION OF THE PROCEDURES FOR COVERED PERSONS OR ENROLLEES TO SELECT A PARTICIPATING HEALTH CARE PROVIDER, INCLUDING HOW TO DETERMINE WHETHER A PARTICIPATING HEALTH CARE PROVIDER IS ACCEPTING NEW [ENROLLEES] PATIENTS.

(11) A DESCRIPTION OF THE PROCEDURES FOR CHANGING PRIMARY CARE PROVIDERS AND SPECIALISTS.

(12) A DESCRIPTION OF THE PROCEDURES BY WHICH [AN] A COVERED PERSON OR ENROLLEE MAY OBTAIN A REFERRAL TO A HEALTH CARE PROVIDER OUTSIDE THE HEALTH INSURANCE POLICY'S OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER NETWORK WHEN THAT PROVIDER NETWORK DOES NOT INCLUDE A HEALTH CARE PROVIDER WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE HEALTH CARE SERVICE NEEDS OF [AN] A COVERED PERSON OR ENROLLEE.

(13) A DESCRIPTION OF THE PROCEDURES THAT [AN] A COVERED PERSON OR ENROLLEE WITH A LIFE-THREATENING, DEGENERATIVE OR DISABLING DISEASE OR CONDITION SHALL FOLLOW AND SATISFY TO BE ELIGIBLE FOR EITHER OF THE FOLLOWING:

(I) [A] A STANDING REFERRAL TO A SPECIALIST WITH CLINICAL EXPERTISE IN TREATING THE DISEASE OR CONDITION[; OR].

(II) [THE] THE DESIGNATION OF A SPECIALIST TO PROVIDE AND
COORDINATE THE COVERED PERSON'S OR ENROLLEE'S PRIMARY AND
SPECIALTY CARE.

(14) A LIST BY SPECIALTY OF THE NAME, ADDRESS AND TELEPHONE
NUMBER OF ALL [PARTICIPATING] HEALTH CARE PROVIDERS
PARTICIPATING IN THE PROVIDER NETWORK FOR THE HEALTH INSURANCE
POLICY OR MA OR CHIP MANAGED CARE PLAN. THE LIST MAY BE A
SEPARATE DOCUMENT AND SHALL BE UPDATED AT LEAST [ANNUALLY.] ONCE
EVERY 90 DAYS OR MORE FREQUENTLY AS MAY BE REQUIRED BY FEDERAL
OR STATE LAW, INCLUDING SECTION 2799A-5 OF THE PUBLIC HEALTH
SERVICE ACT (58 STAT. 682, 42 U.S.C. § 201 ET SEQ.)

(15) A LIST OF THE INFORMATION AVAILABLE TO COVERED PERSONS
OR ENROLLEES OR PROSPECTIVE COVERED PERSONS OR ENROLLEES, UPON
WRITTEN REQUEST, UNDER SUBSECTION (B).

(B) EACH INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL, UPON
WRITTEN REQUEST OF [AN] A COVERED PERSON OR ENROLLEE OR
PROSPECTIVE COVERED PERSON OR ENROLLEE, PROVIDE THE FOLLOWING
WRITTEN INFORMATION:

(1) A LIST OF THE NAMES, BUSINESS ADDRESSES AND OFFICIAL
POSITIONS OF THE MEMBERSHIP OF THE BOARD OF DIRECTORS OR
OFFICERS OF THE INSURER OR MA OR CHIP MANAGED CARE PLAN.

(2) THE PROCEDURES ADOPTED TO PROTECT THE CONFIDENTIALITY OF
MEDICAL RECORDS AND OTHER COVERED PERSON OR ENROLLEE
INFORMATION.

(3) A DESCRIPTION OF THE CREDENTIALING PROCESS FOR HEALTH
CARE PROVIDERS.

(4) A LIST OF THE PARTICIPATING HEALTH CARE PROVIDERS
AFFILIATED WITH PARTICIPATING HOSPITALS.

(5) WHETHER A SPECIFICALLY IDENTIFIED DRUG IS INCLUDED OR
EXCLUDED FROM COVERAGE.

1 (6) A DESCRIPTION OF THE PROCESS BY WHICH A HEALTH CARE
2 PROVIDER CAN PRESCRIBE SPECIFIC DRUGS, DRUGS USED FOR AN OFF-
3 LABEL PURPOSE, BIOLOGICALS AND MEDICATIONS NOT INCLUDED IN THE
4 DRUG FORMULARY FOR PRESCRIPTION DRUGS [OR BIOLOGICALS] WHEN THE
5 FORMULARY'S EQUIVALENT HAS BEEN INEFFECTIVE IN THE TREATMENT OF
6 THE COVERED PERSON'S OR ENROLLEE'S DISEASE OR IF THE DRUG CAUSES
7 OR IS REASONABLY EXPECTED TO CAUSE ADVERSE OR HARMFUL REACTIONS
8 TO THE COVERED PERSON OR ENROLLEE.

9 (7) A DESCRIPTION OF THE PROCEDURES FOLLOWED BY THE INSURER
10 OR MA OR CHIP MANAGED CARE PLAN TO MAKE DECISIONS ABOUT THE
11 EXPERIMENTAL NATURE OF INDIVIDUAL DRUGS, MEDICAL DEVICES OR
12 TREATMENTS.

13 (8) A SUMMARY OF THE METHODOLOGIES USED BY THE INSURER OR MA
14 OR CHIP MANAGED CARE PLAN TO REIMBURSE FOR HEALTH CARE SERVICES.
15 NOTHING IN THIS PARAGRAPH SHALL BE CONSTRUED TO REQUIRE
16 DISCLOSURE OF INDIVIDUAL CONTRACTS OR THE SPECIFIC DETAILS OF
17 ANY FINANCIAL ARRANGEMENT BETWEEN [A] AN INSURER OR MA OR CHIP
18 MANAGED CARE PLAN AND A HEALTH CARE PROVIDER.

19 (9) A DESCRIPTION OF THE PROCEDURES USED IN THE INSURER'S OR
20 MA OR CHIP MANAGED CARE PLAN'S QUALITY ASSURANCE PROGRAM.

21 (10) OTHER INFORMATION AS MAY BE REQUIRED BY THE DEPARTMENT
22 OR THE INSURANCE DEPARTMENT.

23 (C) (1) AN INSURER SHALL INCLUDE A DESCRIPTION OF THE
24 INSURER'S EXTERNAL REVIEW PROCEDURES IN OR ATTACHED TO THE
25 POLICY, CERTIFICATE, MEMBERSHIP BOOKLET, OUTLINE OF COVERAGE OR
26 OTHER EVIDENCE OF COVERAGE THE INSURER PROVIDES TO COVERED
27 PERSONS, INCLUDING WHETHER THE INSURER HAS COMPLIED WITH THE
28 SURPRISE BILLING AND COST-SHARING PROTECTIONS UNDER THE NO
29 SURPRISES ACT (PUB. L. 116-260, DIV. BB, TITLE I, 134 STAT.
30 2758).

1 (2) THE DISCLOSURE REQUIRED BY PARAGRAPH (1) SHALL BE IN A
2 FORMAT AS PRESCRIBED BY THE DEPARTMENT.

3 (3) THE DESCRIPTION OF PROCEDURES REQUIRED UNDER SUBSECTION
4 (A) SHALL INCLUDE:

5 (I) A STATEMENT THAT INFORMS THE COVERED PERSON OF THE RIGHT
6 TO FILE A REQUEST FOR EXTERNAL REVIEW OF AN ADVERSE BENEFIT
7 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, INCLUDING
8 WHETHER THE INSURER HAS COMPLIED WITH THE SURPRISE BILLING AND
9 COST SHARING PROTECTIONS UNDER THE NO SURPRISE ACT.

10 (II) THE TELEPHONE NUMBER AND ADDRESS OF THE DEPARTMENT.

11 (III) A STATEMENT THAT, WHEN FILING A REQUEST FOR AN
12 EXTERNAL REVIEW, THE COVERED PERSON IS REQUIRED TO AUTHORIZE THE
13 RELEASE OF MEDICAL RECORDS OF THE COVERED PERSON THAT MAY BE
14 REQUIRED TO BE REVIEWED FOR THE PURPOSE OF REACHING A DECISION
15 ON THE EXTERNAL REVIEW.

16 (IV) AN EXPLANATION THAT EXTERNAL REVIEW IS AVAILABLE WHEN
17 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
18 DETERMINATION INVOLVES AN ISSUE OF MEDICAL NECESSITY,
19 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR
20 EFFECTIVENESS.

21 SECTION 2. SECTION 2141 OF THE ACT IS AMENDED TO READ:

22 SECTION 2141. INTERNAL COMPLAINT PROCESS FOR COVERED
23 PERSONS.--(A) [A MANAGED CARE PLAN] AN INSURER SHALL ESTABLISH
24 AND MAINTAIN AN INTERNAL COMPLAINT PROCESS WITH TWO LEVELS OF
25 REVIEW BY WHICH [AN ENROLLEE] A COVERED PERSON OR THE COVERED
26 PERSON'S AUTHORIZED REPRESENTATIVE SHALL BE ABLE TO FILE A
27 COMPLAINT [REGARDING A PARTICIPATING HEALTH CARE PROVIDER OR THE
28 COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF THE MANAGED CARE
29 PLAN].

30 (B) THE COMPLAINT PROCESS SHALL CONSIST OF AN INITIAL REVIEW

TO INCLUDE ALL OF THE FOLLOWING:

(1) A REVIEW BY AN INITIAL REVIEW COMMITTEE CONSISTING OF ONE OR MORE EMPLOYEES OF THE [MANAGED CARE PLAN] INSURER.

(2) THE ALLOWANCE OF A WRITTEN OR ORAL COMPLAINT.

(3) THE ALLOWANCE OF WRITTEN DATA OR OTHER INFORMATION.

(4) A REVIEW OR INVESTIGATION OF THE COMPLAINT WHICH SHALL BE COMPLETED WITHIN THIRTY (30) DAYS OF RECEIPT OF THE COMPLAINT.

(5) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON REGARDING THE DECISION OF THE INITIAL REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. NOTICE SHALL INCLUDE THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST FOR A SECOND LEVEL REVIEW OF THE DECISION OF THE INITIAL REVIEW COMMITTEE.

(C) THE COMPLAINT PROCESS SHALL INCLUDE A SECOND LEVEL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

(1) A REVIEW OF THE DECISION OF THE INITIAL REVIEW COMMITTEE BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE INDIVIDUALS WHO DID NOT PARTICIPATE IN THE INITIAL REVIEW. AT LEAST ONE THIRD OF THE SECOND LEVEL REVIEW COMMITTEE SHALL NOT BE EMPLOYED BY THE [MANAGED CARE PLAN] INSURER.

(2) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

(3) A REQUIREMENT THAT THE SECOND LEVEL REVIEW BE COMPLETED WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH REVIEW.

(4) A WRITTEN NOTIFICATION TO THE [ENROLLEE] COVERED PERSON REGARDING THE DECISION OF THE SECOND LEVEL REVIEW COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE NOTICE SHALL INCLUDE THE BASIS FOR THE DECISION AND THE PROCEDURE FOR

1 APPEALING THE DECISION TO THE DEPARTMENT [OR THE INSURANCE
2 DEPARTMENT] .

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

4 SECTION 2141.1. INTERNAL COMPLAINT PROCESS FOR ENROLLEES.--

5 (A) AN MA OR CHIP MANAGED CARE PLAN SHALL ESTABLISH AND
6 MAINTAIN AN INTERNAL COMPLAINT PROCESS BY WHICH AN ENROLLEE OR
7 THE ENROLLEE'S AUTHORIZED REPRESENTATIVE SHALL BE ABLE TO FILE A
8 COMPLAINT.

9 (B) THE COMPLAINT PROCESS SHALL CONSIST OF A REVIEW TO
10 INCLUDE ALL OF THE FOLLOWING:

11 (1) A REVIEW BY A REVIEW COMMITTEE CONSISTING OF ONE OR MORE
12 EMPLOYES OF THE MA OR CHIP MANAGED CARE PLAN.

13 (2) THE ALLOWANCE OF A WRITTEN OR ORAL COMPLAINT.

14 (3) THE ALLOWANCE OF WRITTEN DATA OR OTHER INFORMATION.

15 (4) WRITTEN NOTIFICATION TO THE ENROLLEE OF THE DECISION OF
16 THE REVIEW COMMITTEE WITHIN THIRTY (30) DAYS OF RECEIPT OF THE
17 COMPLAINT, UNLESS THE TIME FRAME FOR DECIDING THE COMPLAINT HAS
18 BEEN EXTENDED BY UP TO FOURTEEN (14) DAYS AT THE REQUEST OF THE
19 ENROLLEE.

20 (5) THE WRITTEN NOTIFICATION OF THE DECISION SHALL INCLUDE
21 THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE A REQUEST
22 FOR A SECOND LEVEL REVIEW OF THE DECISION OF THE REVIEW
23 COMMITTEE, EXCEPT AS PROVIDED IN PARAGRAPH (6).

24 (6) THE WRITTEN NOTIFICATION OF THE DECISION SHALL INCLUDE
25 THE BASIS FOR THE DECISION AND THE PROCEDURE TO FILE AN APPEAL
26 OF A COMPLAINT IF THE COMPLAINT IS ABOUT ONE OF THE FOLLOWING:

27 (I) A DENIAL BECAUSE THE SERVICE OR ITEM IS NOT A COVERED
28 SERVICE.

29 (II) THE FAILURE OF THE MA OR CHIP MANAGED CARE PLAN TO MEET
30 THE REQUIRED TIME FRAMES FOR PROVIDING A SERVICE OR ITEM IN A

1 TIMELY MANNER.

2 (III) THE FAILURE OF THE MA OR CHIP MANAGED CARE PLAN TO
3 DECIDE A COMPLAINT OR GRIEVANCE WITHIN THE REQUIRED TIME FRAMES.

4 (IV) A DENIAL OF PAYMENT BY THE MA OR CHIP MANAGED CARE PLAN
5 AFTER THE SERVICE OR ITEM HAS BEEN DELIVERED BECAUSE THE SERVICE
6 OR ITEM WAS PROVIDED BY A HEALTH CARE PROVIDER NOT ENROLLED IN
7 THE MEDICAL ASSISTANCE PROGRAM.

8 (V) A DENIAL OF PAYMENT BY THE MA OR CHIP MANAGED CARE PLAN
9 AFTER THE SERVICE OR ITEM HAS BEEN DELIVERED BECAUSE THE SERVICE
10 OR ITEM PROVIDED IS NOT A COVERED SERVICE OR ITEM FOR THE
11 ENROLLEE.

12 (VI) A DENIAL OF AN ENROLLEE'S REQUEST TO DISPUTE A
13 FINANCIAL LIABILITY.

14 (C) FOR ALL COMPLAINTS EXCEPT COMPLAINTS LISTED IN
15 SUBSECTION (B) (6), THE COMPLAINT PROCESS SHALL INCLUDE A SECOND
16 LEVEL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

17 (1) A REVIEW OF THE DECISION OF THE REVIEW COMMITTEE BY A
18 SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR MORE
19 INDIVIDUALS WHO DID NOT PARTICIPATE IN THE INITIAL REVIEW. AT
20 LEAST ONE-THIRD OF THE SECOND LEVEL REVIEW COMMITTEE SHALL NOT
21 BE EMPLOYED BY THE MA OR CHIP MANAGED CARE PLAN.

22 (2) A WRITTEN NOTIFICATION TO THE ENROLLEE OF THE RIGHT TO
23 APPEAR BEFORE THE SECOND LEVEL REVIEW COMMITTEE.

24 (3) A WRITTEN NOTIFICATION TO THE ENROLLEE OF THE DECISION
25 OF THE SECOND LEVEL REVIEW COMMITTEE WITHIN FORTY-FIVE (45) DAYS
26 OF RECEIPT OF THE SECOND LEVEL COMPLAINT, WHICH SHALL INCLUDE
27 THE BASIS FOR THE DECISION AND THE PROCEDURE FOR APPEALING THE
28 DECISION TO THE DEPARTMENT.

29 SECTION 4. SECTIONS 2142 AND 2143, SUBDIVISION (H) HEADING
30 OF ARTICLE XXI AND SECTIONS 2151 AND 2152 OF THE ACT ARE AMENDED

TO READ:

SECTION 2142. APPEAL OF COMPLAINT OR ADMINISTRATIVE ADVERSE
BENEFIT DETERMINATION.--[(A) AN ENROLLEE SHALL HAVE FIFTEEN
(15) DAYS FROM RECEIPT OF THE NOTICE OF THE DECISION FROM THE
SECOND LEVEL REVIEW COMMITTEE TO APPEAL THE DECISION TO THE
DEPARTMENT OR THE INSURANCE DEPARTMENT, AS APPROPRIATE.

(B) ALL RECORDS FROM THE INITIAL REVIEW AND SECOND LEVEL
REVIEW SHALL BE TRANSMITTED TO THE APPROPRIATE DEPARTMENT IN THE
MANNER PRESCRIBED. THE ENROLLEE, THE HEALTH CARE PROVIDER OR THE
MANAGED CARE PLAN MAY SUBMIT ADDITIONAL MATERIALS RELATED TO THE
COMPLAINT.]

(A) THE FOLLOWING SHALL APPLY:

(1) A COVERED PERSON MAY APPEAL A DECISION ABOUT THE
COVERAGE, OPERATIONS OR MANAGEMENT POLICIES OF AN INSURER, OTHER
THAN DECISIONS THAT ARE ADVERSE BENEFIT DETERMINATIONS.

(2) AN ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE
SHALL HAVE FIFTEEN (15) DAYS FROM RECEIPT OF THE NOTICE OF
DECISION TO APPEAL THE DECISION TO THE DEPARTMENT IF THE SUBJECT
OF THE COMPLAINT IS LISTED IN SECTION 2141.1(B)(6).

(3) A COVERED PERSON OR ENROLLEE, OR COVERED PERSON'S OR
ENROLLEE'S AUTHORIZED REPRESENTATIVE, SHALL HAVE FIFTEEN (15)
DAYS FROM RECEIPT OF THE NOTICE OF THE DECISION FROM THE SECOND
LEVEL REVIEW COMMITTEE TO APPEAL THE DECISION TO THE DEPARTMENT.

(4) ALL RECORDS FROM THE REVIEW SHALL BE TRANSMITTED TO THE
DEPARTMENT IN THE MANNER PRESCRIBED. THE COVERED PERSON,
ENROLLEE, HEALTH CARE PROVIDER OR INSURER OR MA OR CHIP MANAGED
CARE PLAN MAY SUBMIT ADDITIONAL MATERIALS RELATED TO THE
COMPLAINT.

(B) (1) A COVERED PERSON SHALL HAVE FIFTEEN (15) DAYS FROM
RECEIPT OF THE NOTICE OF A DECISION ON AN ADMINISTRATIVE ADVERSE

1 BENEFIT DETERMINATION CONDUCTED UNDER SECTION 2161.1 TO APPEAL
2 THE DECISION TO THE DEPARTMENT.

3 (2) ALL RECORDS FROM THE INTERNAL CLAIM AND APPEAL PROCEDURE
4 SHALL BE TRANSMITTED TO THE DEPARTMENT IN THE MANNER PRESCRIBED.
5 THE COVERED PERSON, HEALTH CARE PROVIDER OR INSURER MAY SUBMIT
6 ADDITIONAL MATERIALS RELATED TO THE ADMINISTRATIVE ADVERSE
7 BENEFIT DETERMINATION.

8 (C) THE COVERED PERSON OR ENROLLEE MAY BE REPRESENTED BY AN
9 ATTORNEY OR OTHER INDIVIDUAL BEFORE THE APPROPRIATE DEPARTMENT.

10 (D) THE [APPROPRIATE] DEPARTMENT SHALL DETERMINE WHETHER A
11 VIOLATION OF THIS ARTICLE HAS OCCURRED AND MAY IMPOSE ANY
12 PENALTIES AUTHORIZED BY THIS ARTICLE.

13 SECTION 2143. COMPLAINT OR ADMINISTRATIVE ADVERSE BENEFIT
14 DETERMINATION RESOLUTION.--NOTHING IN THIS SUBDIVISION SHALL
15 PREVENT THE DEPARTMENT [OR THE INSURANCE DEPARTMENT] FROM
16 COMMUNICATING WITH THE COVERED PERSON OR ENROLLEE[,] OR THE
17 HEALTH CARE PROVIDER [OR THE], INSURER OR MA OR CHIP MANAGED
18 CARE PLAN AS APPROPRIATE TO ASSIST IN THE RESOLUTION OF A
19 COMPLAINT OR ADMINISTRATIVE ADVERSE BENEFIT DETERMINATION. SUCH
20 COMMUNICATION MAY OCCUR AT ANY TIME DURING THE [COMPLAINT]
21 PROCESS.

22 (H) UTILIZATION REVIEW ENTITY STANDARDS.

23 SECTION 2151. CERTIFICATION.--(A) A UTILIZATION REVIEW
24 ENTITY MAY NOT REVIEW HEALTH CARE SERVICES DELIVERED OR PROPOSED
25 TO BE DELIVERED IN THIS COMMONWEALTH UNLESS THE ENTITY IS
26 CERTIFIED BY THE DEPARTMENT TO PERFORM UTILIZATION REVIEW. [A
27 UTILIZATION REVIEW ENTITY OPERATING IN THIS COMMONWEALTH ON OR
28 BEFORE THE EFFECTIVE DATE OF THIS ARTICLE SHALL HAVE ONE YEAR
29 FROM THE EFFECTIVE DATE OF THIS ARTICLE TO APPLY FOR
30 CERTIFICATION.]

1 (B) THE DEPARTMENT [SHALL] MAY GRANT CERTIFICATION TO A
2 UTILIZATION REVIEW ENTITY THAT MEETS THE REQUIREMENTS OF THIS
3 SECTION. CERTIFICATION SHALL BE RENEWED EVERY THREE YEARS UNLESS
4 OTHERWISE SUBJECT TO ADDITIONAL REVIEW, SUSPENSION OR REVOCATION
5 BY THE DEPARTMENT.

6 (C) THE DEPARTMENT MAY ADOPT A NATIONALLY RECOGNIZED
7 ACCREDITING BODY'S STANDARDS TO CERTIFY UTILIZATION REVIEW
8 ENTITIES TO THE EXTENT THE STANDARDS MEET OR EXCEED THE
9 STANDARDS SET FORTH IN THIS ARTICLE.

10 (D) THE DEPARTMENT MAY PRESCRIBE APPLICATION AND RENEWAL
11 FEES FOR CERTIFICATION. THE FEES SHALL REFLECT THE
12 ADMINISTRATIVE COSTS OF CERTIFICATION [AND SHALL BE DEPOSITED IN
13 THE GENERAL FUND].

14 (E) [A LICENSED INSURER OR A] AN INSURER OR MA OR CHIP
15 MANAGED CARE PLAN WITH A CERTIFICATE OF AUTHORITY SHALL COMPLY
16 WITH THE STANDARDS AND PROCEDURES OF THIS SUBDIVISION BUT SHALL
17 NOT BE REQUIRED TO OBTAIN SEPARATE CERTIFICATION AS A
18 UTILIZATION REVIEW ENTITY.

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

21 (1) RESPOND TO INQUIRIES RELATING TO UTILIZATION REVIEW
22 DETERMINATIONS BY:

23 (I) PROVIDING TOLL-FREE TELEPHONE ACCESS AT LEAST FORTY (40)
24 HOURS PER WEEK DURING NORMAL BUSINESS HOURS;

25 (II) MAINTAINING A TELEPHONE ANSWERING SERVICE OR RECORDING
26 SYSTEM DURING NONBUSINESS HOURS; AND

27 (III) RESPONDING TO EACH TELEPHONE CALL RECEIVED BY THE
28 ANSWERING SERVICE OR RECORDING SYSTEM REGARDING A UTILIZATION
29 REVIEW DETERMINATION WITHIN ONE (1) BUSINESS DAY OF THE RECEIPT
30 OF THE CALL.

(2) PROTECT THE CONFIDENTIALITY OF COVERED PERSON OR ENROLLEE MEDICAL RECORDS AS SET FORTH IN SECTION 2131.

(3) ENSURE THAT A HEALTH CARE PROVIDER IS ABLE TO VERIFY THAT AN INDIVIDUAL REQUESTING INFORMATION ON BEHALF OF THE INSURER OR MA OR CHIP MANAGED CARE PLAN IS [A LEGITIMATE] AN AUTHORIZED REPRESENTATIVE OF THE INSURER OR MA OR CHIP MANAGED CARE PLAN.

(4) CONDUCT UTILIZATION REVIEWS BASED ON THE MEDICAL NECESSITY [AND], APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE OR EFFECTIVENESS OF THE HEALTH CARE SERVICE BEING REVIEWED [AND PROVIDE NOTIFICATION WITHIN THE FOLLOWING TIME FRAMES:].

(4.1) IF PERFORMING A UTILIZATION REVIEW FOR A REQUEST FOR HEALTH CARE SERVICES FOR AN COVERED PERSON OR ENROLLEE OF AN INSURER OR MA OR CHIP MANAGED CARE PLAN, 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] THE TIME FRAME SPECIFIED IN SECTION 2155.

(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.

(5) ENSURE THAT PERSONNEL CONDUCTING A UTILIZATION REVIEW HAVE CURRENT LICENSES IN GOOD STANDING OR OTHER REQUIRED CREDENTIALS, WITHOUT RESTRICTIONS, FROM THE APPROPRIATE AGENCY.

(6) PROVIDE ALL DECISIONS IN WRITING TO INCLUDE THE BASIS AND CLINICAL RATIONALE FOR THE DECISION.

(7) NOTIFY THE HEALTH CARE PROVIDER OF ADDITIONAL FACTS OR DOCUMENTS REQUIRED TO COMPLETE THE UTILIZATION REVIEW WITHIN [FORTY-EIGHT (48) HOURS OF RECEIPT OF THE REQUEST FOR REVIEW] THE TIME FRAMES SPECIFIED IN SECTION 2155.

(8) MAINTAIN A WRITTEN RECORD OF UTILIZATION REVIEW DECISIONS ADVERSE TO COVERED PERSONS OR ENROLLEES FOR NOT LESS THAN THREE (3) YEARS, INCLUDING A DETAILED JUSTIFICATION AND ALL REQUIRED NOTIFICATIONS TO THE HEALTH CARE PROVIDER AND THE COVERED PERSON OR ENROLLEE.

(B) COMPENSATION TO ANY PERSON OR ENTITY PERFORMING UTILIZATION REVIEW MAY NOT CONTAIN INCENTIVES, DIRECT OR INDIRECT, FOR THE PERSON OR ENTITY TO APPROVE OR DENY PAYMENT FOR THE DELIVERY OF ANY HEALTH CARE SERVICE.

(C) UTILIZATION REVIEW THAT RESULTS IN A DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE SHALL BE MADE BY A LICENSED PHYSICIAN THAT MEETS THE QUALIFICATIONS IN SECTION 2155(C), EXCEPT AS PROVIDED IN [SUBSECTION (D)] SUBSECTIONS (D) AND (E).

(D) A LICENSED PSYCHOLOGIST MAY PERFORM A UTILIZATION REVIEW FOR BEHAVIORAL HEALTH CARE SERVICES WITHIN THE PSYCHOLOGIST'S SCOPE OF PRACTICE IF THE PSYCHOLOGIST'S CLINICAL EXPERIENCE PROVIDES SUFFICIENT EXPERIENCE TO REVIEW THAT SPECIFIC BEHAVIORAL HEALTH CARE SERVICE. THE USE OF A LICENSED PSYCHOLOGIST TO PERFORM A UTILIZATION REVIEW OF A BEHAVIORAL HEALTH CARE SERVICE SHALL BE APPROVED BY THE DEPARTMENT AS PART OF THE CERTIFICATION PROCESS UNDER SECTION 2151. A LICENSED PSYCHOLOGIST SHALL NOT REVIEW THE DENIAL OF PAYMENT FOR A HEALTH CARE SERVICE INVOLVING INPATIENT CARE OR A PRESCRIPTION DRUG.

(E) A LICENSED DENTIST MAY PERFORM A UTILIZATION REVIEW FOR

DENTAL SERVICES WITHIN THE DENTIST'S SCOPE OF PRACTICE IF THE
DENTIST'S CLINICAL EXPERIENCE PROVIDES SUFFICIENT EXPERIENCE TO
REVIEW THAT SPECIFIC DENTAL SERVICE. THE USE OF A LICENSED
DENTIST TO PERFORM A UTILIZATION REVIEW OF A DENTAL SERVICE
SHALL BE APPROVED BY THE DEPARTMENT AS PART OF THE CERTIFICATION
PROCESS UNDER SECTION 2151.

SECTION 5. ARTICLE XXI OF THE ACT IS AMENDED BY ADDING A
SUBDIVISION TO READ:

(H.1) UTILIZATION REVIEW STANDARDS.

SECTION 2153. PROVIDER PORTAL.

(A) ESTABLISHMENT OF PROVIDER PORTAL.--WITHIN 18 MONTHS
FOLLOWING THE EFFECTIVE DATE OF THIS SECTION, AN INSURER OR MA
OR CHIP MANAGED CARE PLAN SHALL ESTABLISH A PROVIDER PORTAL THAT
INCLUDES, AT MINIMUM, THE FOLLOWING FEATURES:

(1) ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION
REQUESTS.

(2) ACCESS TO THE INSURER'S OR MA OR CHIP MANAGED CARE
PLAN'S APPLICABLE MEDICAL POLICIES.

(3) INFORMATION NECESSARY TO REQUEST A PEER-TO-PEER
REVIEW.

(4) CONTACT INFORMATION FOR THE INSURER'S OR MA OR CHIP
MANAGED CARE PLAN'S RELEVANT CLINICAL OR ADMINISTRATIVE
STAFF.

(5) FOR PRIOR AUTHORIZATION SERVICE NOT SUBJECT TO
ELECTRONIC SUBMISSION VIA THE PROVIDER PORTAL, COPIES OF
APPLICABLE SUBMISSION FORMS.

(6) INSTRUCTIONS FOR THE SUBMISSION OF PRIOR
AUTHORIZATION REQUESTS IF THE INSURER'S OR MA OR CHIP MANAGED
CARE PLAN'S PROVIDER PORTAL IS UNAVAILABLE FOR ANY REASON.

(B) TRAINING AND SUPPORT FOR PORTAL USE.--WITHIN SIX MONTHS

1 FOLLOWING THE ESTABLISHMENT OF A PROVIDER PORTAL UNDER
2 SUBSECTION (A), AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
3 MAKE AVAILABLE TO HEALTH CARE PROVIDERS AND THEIR AFFILIATED OR
4 EMPLOYED STAFF ACCESS TO TRAINING ON THE USE OF THE INSURER'S OR
5 MA OR CHIP MANAGED CARE PLAN'S PROVIDER PORTAL.

6 (C) REQUIRED USE OF PROVIDER PORTAL.--

7 (1) WITHIN 18 MONTHS FOLLOWING THE ESTABLISHMENT OF A
8 PROVIDER PORTAL UNDER SUBSECTION (A), A HEALTH CARE PROVIDER
9 SEEKING PRIOR AUTHORIZATION SHALL SUBMIT THE REQUEST VIA AN
10 INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PROVIDER PORTAL
11 UNLESS AN EXCEPTION APPLIES.

12 (2) AN INSURER OR MA OR CHIP MANAGED CARE PLAN MAY
13 REQUIRE A HEALTH CARE PROVIDER TO SUBMIT A PRIOR
14 AUTHORIZATION REQUEST THROUGH THE PROVIDER PORTAL UNLESS ANY
15 OF THE FOLLOWING EXCEPTIONS APPLIES:

16 (I) THE PORTAL IS NOT AVAILABLE AND OPERATIONAL AT
17 THE TIME OF ATTEMPTED SUBMISSION.

18 (II) THE HEALTH CARE PROVIDER DOES NOT HAVE ACCESS
19 TO THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
20 OPERATIONAL PROVIDER PORTAL.

21 (III) THE HEALTH CARE PROVIDER SATISFIES AN
22 ALLOWANCE BY THE INSURER OR MA OR CHIP MANAGED CARE PLAN
23 FOR SUBMISSION OTHER THAN THROUGH THE PROVIDER PORTAL.

24 SECTION 2154. MEDICAL POLICIES AND CLINICAL REVIEW CRITERIA.

25 (A) MEDICAL POLICIES.--

26 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
27 MAKE AVAILABLE ITS CURRENT MEDICAL POLICIES THROUGH THE
28 INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PUBLICLY
29 ACCESSIBLE INTERNET WEBSITE AND PROVIDER PORTAL.

30 (2) EACH MEDICAL POLICY DEVELOPED BY AN INSURER OR MA OR

1 CHIP MANAGED CARE PLAN SHALL IDENTIFY THE CLINICAL REVIEW
2 CRITERIA USED IN THE POLICY'S DEVELOPMENT. THE INSURER OR MA
3 OR CHIP MANAGED CARE PLAN SHALL IDENTIFY ANY THIRD-PARTY
4 LICENSURE RESTRICTIONS PREVENTING DISCLOSURE OF ALL OR PART
5 OF CLINICAL REVIEW CRITERIA.

6 (3) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
7 REVIEW EACH ADOPTED MEDICAL POLICY ON AT LEAST AN ANNUAL
8 BASIS.

9 (4) (I) AN INSURER OR MA OR CHIP MANAGED CARE PLAN
10 SHALL NOTIFY PROVIDERS OF A CHANGE TO A MEDICAL POLICY AS
11 FOLLOWS:

12 (A) IN THE CASE OF POLICY CHANGE DUE TO A CHANGE
13 IN FEDERAL OR STATE LAW OR BINDING AGENCY GUIDANCE,
14 WHEN THE REQUIRED IMPLEMENTATION DATE OF THAT POLICY
15 CHANGE IS SOONER THAN 30 DAYS, AS SOON AS
16 PRACTICABLE.

17 (B) IN THE CASE OF A CHANGE TO A MEDICAL POLICY
18 THAT MODIFIES, ELIMINATES OR SUSPENDS EITHER CLINICAL
19 OR ADMINISTRATIVE CRITERIA AND THAT DIRECTLY RESULTS
20 IN LESS RESTRICTIVE COVERAGE OF A GIVEN SERVICE,
21 WITHIN 30 DAYS AFTER APPLICATION OF THE CHANGE.

22 (C) IN CASES OTHER THAN IN CLAUSES (A) AND (B),
23 AT LEAST 30 DAYS PRIOR TO APPLICATION OF THE CHANGE.

24 (II) A CHANGE NOTIFICATION MAY BE PROVIDED THROUGH
25 REASONABLE MEANS, INCLUDING POSTING OF AN UPDATED AND
26 DATED MEDICAL POLICY REFLECTING THE CHANGE.

27 (B) CLINICAL REVIEW CRITERIA.--

28 (1) CLINICAL REVIEW CRITERIA ADOPTED BY AN INSURER OR MA
29 OR CHIP MANAGED CARE PLAN AT THE TIME OF MEDICAL POLICY
30 DEVELOPMENT OR REVIEW SHALL:

1 (I) BE BASED ON APPLICABLE NATIONALLY RECOGNIZED
2 MEDICAL STANDARDS.

3 (II) BE CONSISTENT WITH APPLICABLE GOVERNMENTAL
4 GUIDELINES.

5 (III) PROVIDE FOR THE DELIVERY OF A HEALTH CARE
6 SERVICE IN A CLINICALLY APPROPRIATE TYPE, FREQUENCY AND
7 SETTING AND FOR A CLINICALLY APPROPRIATE DURATION.

8 (IV) REFLECT THE CURRENT MEDICAL AND SCIENTIFIC
9 EVIDENCE REGARDING EMERGING PROCEDURES, CLINICAL
10 GUIDELINES AND BEST PRACTICES AS ARTICULATED IN
11 INDEPENDENT, PEER-REVIEWED MEDICAL LITERATURE.

12 (2) NOTHING IN THIS SECTION SHALL REQUIRE AN INSURER OR
13 MA OR CHIP MANAGED CARE PLAN TO PROVIDE COVERAGE FOR A HEALTH
14 CARE SERVICE TO A COVERED PERSON OR ENROLLEE THAT IS
15 OTHERWISE EXCLUDED FROM COVERAGE UNDER A HEALTH INSURANCE
16 POLICY OR AN AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES.
17 SECTION 2155. PRIOR AUTHORIZATION REVIEW.

18 (A) GENERAL RULE.--

19 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
20 MAKE A DETERMINATION RELATING TO PRIOR AUTHORIZATION BASED ON
21 THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S REVIEW OF A
22 PRIOR AUTHORIZATION REQUEST AND THE FOLLOWING:

23 (I) THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
24 MEDICAL POLICY.

25 (II) THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
26 ADMINISTRATIVE POLICY.

27 (III) ALL MEDICAL INFORMATION RELATED TO THE
28 ENROLLEE OR COVERED PERSON.

29 (IV) ANY MEDICAL OR SCIENTIFIC EVIDENCE SUBMITTED BY
30 THE REQUESTING PROVIDER.

1 (2) AT THE TIME OF REVIEW, AN INSURER OR MA OR CHIP
2 MANAGED CARE PLAN SHALL VERIFY THE COVERED PERSON'S OR
3 ENROLLEE'S ELIGIBILITY FOR COVERAGE UNDER THE TERMS OF THE
4 APPLICABLE HEALTH INSURANCE POLICY OR AN AGREEMENT WITH THE
5 DEPARTMENT OF HUMAN SERVICES.

6 (3) APPEALS OF ADMINISTRATIVE ADVERSE BENEFIT
7 DETERMINATIONS SHALL BE SUBJECT TO THE COMPLAINT PROCESS IN
8 SECTION 2142.

9 (B) LIST OF SERVICES SUBJECT TO REVIEW.--AN INSURER OR MA OR
10 CHIP MANAGED CARE PLAN SHALL MAKE AVAILABLE A LIST, POSTED IN A
11 PUBLICLY ACCESSIBLE FORMAT AND LOCATION ON THE INSURER'S OR MA
12 OR CHIP MANAGED CARE PLAN'S PUBLICLY ACCESSIBLE INTERNET
13 WEBSITE, THAT INDICATES THE HEALTH CARE SERVICES FOR WHICH THE
14 INSURER OR MA OR CHIP MANAGED CARE PLAN REQUIRES PRIOR
15 AUTHORIZATION.

16 (C) INFORMATION SUBMISSION.--

17 (1) UPON RECEIPT OF A SUBMISSION OF A PRIOR
18 AUTHORIZATION REQUEST, AN INSURER, MCO OR CHIP MANAGED CARE
19 PLAN SHALL NOTIFY THE HEALTH CARE PROVIDER SUBMITTING THE
20 PRIOR AUTHORIZATION REQUEST OF ANY MISSING INFORMATION NEEDED
21 BY THE INSURER, MCO OR CHIP MANAGED CARE PLAN TO MAKE A PRIOR
22 AUTHORIZATION DETERMINATION. AN INSURER, MCO OR CHIP MANAGED
23 CARE PLAN SHALL IDENTIFY THE MISSING INFORMATION NECESSARY TO
24 MAKE A PRIOR AUTHORIZATION DETERMINATION WITH SUFFICIENT
25 SPECIFICITY TO ENABLE THE HEALTH CARE PROVIDER TO SUBMIT THE
26 INFORMATION TO ALLOW THE INSURER TO MAKE A DETERMINATION IN
27 ACCORDANCE WITH THIS CHAPTER.

28 (2) IF AN INSURER OR MA OR CHIP MANAGED CARE PLAN
29 REQUIRES A PARTICIPATING HEALTH CARE PROVIDER TO TRANSMIT
30 MEDICAL RECORDS IN SUPPORT OF A PRIOR AUTHORIZATION REQUEST

1 ELECTRONICALLY, AND A HEALTH CARE PROVIDER IS CAPABLE OF
2 TRANSMITTING MEDICAL RECORDS IN SUPPORT OF A PRIOR
3 AUTHORIZATION REQUEST ELECTRONICALLY, THE HEALTH CARE
4 PROVIDER SHALL ENSURE THAT THE INSURER OR MA OR CHIP MANAGED
5 CARE PLAN HAS ELECTRONIC ACCESS TO THE MEDICAL RECORDS,
6 INCLUDING ABILITY TO PRINT ANY MEDICAL RECORDS TRANSMITTED
7 ELECTRONICALLY, SUBJECT TO APPLICABLE LAW AND THE HEALTH CARE
8 PROVIDER'S CORPORATE POLICIES. THE INABILITY OF A HEALTH CARE
9 PROVIDER TO PROVIDE ELECTRONIC ACCESS SHALL NOT CONSTITUTE A
10 REASON TO DENY AN AUTHORIZATION REQUEST.

11 (D) CLINICAL KNOWLEDGE OF REVIEWER.--

12 (1) OTHER THAN AN ADMINISTRATIVE DENIAL OF A PRIOR
13 AUTHORIZATION REQUEST, A REQUEST FOR PRIOR AUTHORIZATION MAY
14 ONLY BE DENIED UPON REVIEW BY EITHER OF THE FOLLOWING:

15 (I) A LICENSED HEALTH CARE PROVIDER WITH APPROPRIATE
16 TRAINING, KNOWLEDGE OR EXPERIENCE IN THE SAME OR SIMILAR
17 SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON THE
18 HEALTH CARE SERVICE IN QUESTION.

19 (II) A LICENSED HEALTH CARE PROVIDER, IN
20 CONSULTATION WITH AN APPROPRIATELY QUALIFIED THIRD-PARTY
21 HEALTH CARE PROVIDER, LICENSED IN THE SAME OR SIMILAR
22 MEDICAL SPECIALTY AS THE REQUESTING HEALTH CARE PROVIDER
23 OR TYPE OF HEALTH CARE PROVIDER THAT TYPICALLY MANAGES
24 THE COVERED PERSON'S OR ENROLLEE'S ASSOCIATED CONDITION,
25 EXCEPT THAT ANY COMPENSATION PAID TO THE CONSULTING
26 HEALTH CARE PROVIDER MAY NOT BE CONTINGENT UPON THE
27 OUTCOME OF THE REVIEW.

28 (2) (RESERVED).

29 (E) PEER-TO-PEER REVIEW AVAILABLE.--IN THE CASE OF A DENIED
30 PRIOR AUTHORIZATION OTHER THAN AN ADMINISTRATIVE ADVERSE BENEFIT

1 DETERMINATION OF A CLAIM BY A COVERED PERSON OR AN MA OR CHIP
2 MANAGED CARE PLAN'S DENIAL OF A PRIOR AUTHORIZATION REQUEST THAT
3 DOES NOT INVOLVE MEDICAL JUDGMENT, AN INSURER OR MA OR CHIP
4 MANAGED CARE PLAN SHALL MAKE AVAILABLE TO THE REQUESTING
5 PROVIDER A LICENSED MEDICAL PROFESSIONAL FOR A PEER-TO-PEER
6 REVIEW DISCUSSION. THE PEER-TO-PEER REVIEWER PROVIDED BY THE
7 INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL MEET THE STANDARDS
8 SPECIFIED IN SUBSECTION (C) AND HAVE AUTHORITY TO MODIFY OR
9 OVERTURN THE PRIOR AUTHORIZATION DECISION. THE FOLLOWING SHALL
10 APPLY:

11 (1) THE PROCEDURE FOR REQUESTING A PEER-TO-PEER REVIEW,
12 INCLUDING CONTACT INFORMATION FOR THE INSURER OR ITS
13 UTILIZATION REVIEW ENTITY, OR MA OR CHIP MANAGED CARE PLAN OR
14 ITS UTILIZATION REVIEW ENTITY, SHALL BE AVAILABLE ON THE
15 INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S PUBLICLY
16 ACCESSIBLE INTERNET WEBSITE OR PROVIDER PORTAL.

17 (2) A PROVIDER MAY REQUEST A PEER-TO-PEER REVIEW
18 DISCUSSION:

19 (I) DURING NORMAL BUSINESS HOURS.

20 (II) OUTSIDE NORMAL BUSINESS HOURS, SUBJECT TO
21 REASONABLE LIMITATIONS ON THE AVAILABILITY OF QUALIFIED
22 INSURER OR MA OR CHIP MANAGED CARE PLAN OR UTILIZATION
23 REVIEW ENTITY STAFF.

24 (F) PEER-TO-PEER PROXY.--

25 (1) A HEALTH CARE PROVIDER MAY DESIGNATE, AND AN INSURER
26 OR MA OR CHIP MANAGED CARE PLAN SHALL ACCEPT, ANOTHER
27 LICENSED MEMBER OF THE PROVIDER'S AFFILIATED OR EMPLOYED
28 CLINICAL STAFF WITH KNOWLEDGE OF THE COVERED PERSON'S OR
29 ENROLLEE'S CONDITION AND REQUESTED PROCEDURE AS A QUALIFIED
30 PROXY FOR PURPOSES OF COMPLETING A PEER-TO-PEER DISCUSSION.

1 (2) INDIVIDUALS ELIGIBLE TO RECEIVE A PROXY DESIGNATION
2 SHALL BE LIMITED TO LICENSED HEALTH CARE PROVIDERS WHOSE
3 ACTUAL AUTHORITY AND SCOPE OF PRACTICE IS INCLUSIVE OF
4 PERFORMING OR PRESCRIBING THE REQUESTED HEALTH CARE SERVICE.

5 (3) AUTHORITY MAY BE ESTABLISHED THROUGH A SUPERVISING
6 HEALTH CARE PROVIDER CONSISTENT WITH APPLICABLE STATE LAW FOR
7 NONPHYSICIAN PRACTITIONERS.

8 (4) THE INSURER OR MA OR CHIP MANAGED CARE PLAN MUST
9 ACCEPT AND REVIEW THE INFORMATION SUBMITTED BY OTHER MEMBERS
10 OF A HEALTH CARE PROVIDER'S AFFILIATED OR EMPLOYED STAFF IN
11 SUPPORT OF A PRIOR AUTHORIZATION REQUEST.

12 (5) THE INSURER OR MA OR CHIP MANAGED CARE PLAN MAY NOT
13 LIMIT INTERACTIONS WITH AN INSURER'S OR MA OR CHIP MANAGED
14 CARE PLAN'S CLINICAL STAFF SOLELY TO THE REQUESTING HEALTH
15 CARE PROVIDER.

16 (G) PEER-TO-PEER TIMELINE.--

17 (1) A PEER-TO-PEER DISCUSSION SHALL BE AVAILABLE TO A
18 REQUESTING HEALTH CARE PROVIDER FROM THE TIME OF A PRIOR
19 AUTHORIZATION DENIAL UNTIL THE INTERNAL GRIEVANCE PROCESS OR
20 INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS COMMENCES.

21 (2) IF A PEER-TO-PEER DISCUSSION IS AVAILABLE PRIOR TO
22 ADJUDICATING A PRIOR AUTHORIZATION REQUEST, THE PEER-TO-PEER
23 DISCUSSION SHALL BE OFFERED WITHIN THE TIME LINES SPECIFIED
24 IN THIS SUBSECTION OR SUBSECTION (H).

25 (H) REVIEW TIME LINES FOR REQUESTS SUBMITTED TO AN MA OR
26 CHIP MANAGED CARE PLAN.--

27 (1) AN MA OR CHIP MANAGED CARE PLAN'S DECISION TO
28 APPROVE OR DENY PRIOR AUTHORIZATION SHALL BE COMMUNICATED
29 WITHIN TWO BUSINESS DAYS OF THE RECEIPT OF ALL SUPPORTING
30 INFORMATION REASONABLY NECESSARY TO COMPLETE THE REVIEW.

1 (2) IF AT ANY TIME AFTER REQUESTING PRIOR AUTHORIZATION
2 THE PROVIDER DETERMINES THE ENROLLEE'S MEDICAL CONDITION
3 REQUIRES EMERGENCY SERVICES, THE EMERGENCY SERVICES MAY BE
4 PROVIDED UNDER SECTION 2116.

5 (3) THE FOLLOWING SHALL APPLY:

6 (I) IF A PRIOR AUTHORIZATION REQUEST IS MISSING
7 CLINICAL INFORMATION THAT IS REASONABLY NECESSARY TO
8 CONSTITUTE A PRIOR AUTHORIZATION REQUEST, THE MA OR CHIP
9 MANAGED CARE PLAN SHALL NOTIFY THE HEALTH CARE PROVIDER
10 OF THE SPECIFIC INFORMATION NECESSARY TO COMPLETE THE
11 REVIEW AS SOON AS POSSIBLE, BUT NOT LATER THAN 48 HOURS
12 AFTER RECEIPT OF THE PRIOR AUTHORIZATION REQUEST.

13 (II) THE REQUESTING HEALTH CARE PROVIDER OR A MEMBER
14 OF THE REQUESTING HEALTH CARE PROVIDER'S CLINICAL OR
15 ADMINISTRATIVE STAFF MAY SUBMIT THE SPECIFIED INFORMATION
16 WITHIN 14 DAYS OF THE NOTIFICATION THAT CLINICAL
17 INFORMATION IS MISSING.

18 (III) IF ADDITIONAL INFORMATION IS REQUESTED, THE MA
19 OR CHIP MANAGED CARE PLAN SHALL COMMUNICATE A DECISION ON
20 THE PRIOR AUTHORIZATION REQUEST WITHIN TWO BUSINESS DAYS
21 OF RECEIVING THE ADDITIONAL INFORMATION.

22 (4) AN MA OR CHIP MANAGED CARE PLAN MAY SUPPLEMENT
23 SUBMITTED INFORMATION BASED ON CURRENT CLINICAL RECORDS OR
24 OTHER CURRENT MEDICAL INFORMATION FOR AN ENROLLEE AS
25 AVAILABLE, IF THE SUPPLEMENTAL INFORMATION IS ALSO MADE
26 AVAILABLE TO THE ENROLLEE OR HEALTH CARE PROVIDER AS PART OF
27 THE ENROLLEE'S AUTHORIZATION CASE FILE UPON REQUEST. IN
28 RESPONSE TO A REQUEST FOR MISSING CLINICAL INFORMATION, AN MA
29 OR CHIP MANAGED CARE PLAN SHALL ACCEPT SUPPLEMENTAL
30 INFORMATION FROM A MEMBER OF THE HEALTH CARE PROVIDER'S

1 CLINICAL STAFF.

2 (I) REVIEW TIME LINES.--DETERMINATIONS ON PRIOR
3 AUTHORIZATION REQUESTS THAT MAY BE SUBJECT TO THE ADVERSE
4 BENEFIT DETERMINATION PROCESSES SHALL BE IN ACCORDANCE WITH THE
5 FOLLOWING, UNLESS OTHERWISE REQUIRED BY FEDERAL LAW OR
6 REGULATION:

7 (1) FOR A REQUEST RELATED TO AN URGENT HEALTH CARE
8 SERVICE:

9 (I) IF THE URGENT HEALTH CARE SERVICE HAS NOT YET
10 BEEN INITIATED, AS SOON AS POSSIBLE, BUT NOT MORE THAN 72
11 HOURS.

12 (II) IF RELATED TO AN ONGOING URGENT HEALTH CARE
13 SERVICE AND THE REQUEST IS MADE AT LEAST 24 HOURS PRIOR
14 TO REDUCTION OR TERMINATION OF THE TREATMENT, WITHIN 24
15 HOURS.

16 (2) FOR A REQUEST INVOLVING CONCURRENT CARE OTHER THAN
17 AS SET FORTH IN PARAGRAPH (1) (II), SUFFICIENTLY IN ADVANCE TO
18 PERMIT AN APPEAL BEFORE REDUCTION OR TERMINATION OF THE
19 ONGOING TREATMENT.

20 (3) FOR PRIOR AUTHORIZATION REQUESTS OTHER THAN AS
21 SPECIFIED IN PARAGRAPHS (1) AND (2), WITHIN 15 DAYS. THE 15-
22 DAY DEADLINE MAY BE EXTENDED BY THE INSURER SUBJECT TO THE
23 FOLLOWING LIMITATIONS:

24 (I) UPON RECEIPT OF THE PRIOR AUTHORIZATION REQUEST,
25 THE INSURER PROVIDED NOTIFICATION OF MISSING INFORMATION
26 UNDER SECTION 2155(C) (1).

27 (II) THE NOTIFICATION OF MISSING INFORMATION WAS
28 COMMUNICATED AS SOON AS POSSIBLE FOLLOWING THE SUBMISSION
29 OF THE PRIOR AUTHORIZATION REQUEST TO ALLOW AN
30 OPPORTUNITY TO RESPOND PRIOR TO THE EXPIRATION OF THE 15-

1 DAY DEADLINE WITH THE IDENTIFIED MISSING INFORMATION.

2 (III) IF THE HEALTH CARE PROVIDER SATISFIED THE
3 REQUIREMENTS FOR AN INSURER TO GRANT AN EXTENSION, THE
4 INSURER MAY EXTEND THE DEADLINE FOR AT LEAST 45 DAYS TO
5 ALLOW THE PROVIDER TO RESPOND. UPON RECEIPT OF THE
6 MISSING INFORMATION, THE INSURER SHALL RENDER A DECISION
7 WITHOUT DELAY.

8 (IV) NO INSURER SHALL UNREASONABLY DELAY OR WITHHOLD
9 THE SPECIFIC NOTICE OF ADDITIONAL INFORMATION NEEDED TO
10 COMPLETE A REVIEW OF A PRIOR AUTHORIZATION REQUEST.

11 (V) NOTHING IN THIS PARAGRAPH SHALL REQUIRE AN
12 INSURER TO EXTEND THE INITIAL 15-DAY DEADLINE.

13 (4) FOR A REQUEST RELATED TO A PRESCRIPTION DRUG
14 AUTHORIZATION REQUEST OR STEP THERAPY REQUEST:

15 (I) IF THE REQUEST IS URGENT, WITHIN 24 HOURS.

16 (II) IF THE REQUEST IS NOT URGENT, WITHIN TWO
17 BUSINESS DAYS, BUT NOT MORE THAN 72 HOURS.

18 (J) CLOSELY RELATED SERVICES.--IF A HEALTH CARE PROVIDER
19 PERFORMS A CLOSELY RELATED SERVICE, AN INSURER OR MA OR CHIP
20 MANAGED CARE PLAN MAY NOT DENY A CLAIM FOR THE CLOSELY RELATED
21 SERVICE FOR FAILURE OF THE HEALTH CARE PROVIDER TO SEEK OR
22 OBTAIN PRIOR AUTHORIZATION, IF:

23 (1) THE HEALTH CARE PROVIDER NOTIFIES THE INSURER OR MA
24 OR CHIP MANAGED CARE PLAN OF THE PERFORMANCE OF THE CLOSELY
25 RELATED SERVICE NO LATER THAN THREE BUSINESS DAYS FOLLOWING
26 COMPLETION OF THE SERVICE BUT PRIOR TO THE SUBMISSION OF THE
27 CLAIM FOR PAYMENT. THE SUBMISSION OF THE NOTIFICATION SHALL
28 INCLUDE THE SUBMISSION OF ALL RELEVANT CLINICAL INFORMATION
29 NECESSARY FOR THE INSURER OR MA OR CHIP MANAGED CARE PLAN TO
30 EVALUATE THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE

1 SERVICE.

2 (2) NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO
3 LIMIT AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S
4 RETROSPECTIVE UTILIZATION REVIEW OF MEDICAL NECESSITY AND
5 APPROPRIATENESS OF THE CLOSELY RELATED SERVICE, NOR LIMIT THE
6 NEED FOR VERIFICATION OF THE COVERED PERSON'S OR ENROLLEE'S
7 ELIGIBILITY FOR COVERAGE.

8 SECTION 2156. STEP THERAPY CONSIDERATIONS.

9 (A) STEP THERAPY CRITERIA.--IF AN INSURER OR MA OR CHIP
10 MANAGED CARE PLAN HAS A MEDICAL POLICY THAT INCLUDES STEP
11 THERAPY CRITERIA FOR A PRESCRIPTION DRUG, THE FOLLOWING APPLY:

12 (1) AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL
13 CONSIDER AS PART OF THE INSURER'S OR MA OR CHIP MANAGED CARE
14 PLAN'S PRIOR AUTHORIZATION PROCESS A REQUEST FOR AN EXCEPTION
15 TO THE INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S STEP
16 THERAPY CRITERIA.

17 (2) A REQUEST FOR AN EXCEPTION TO AN INSURER'S OR MA OR
18 CHIP MANAGED CARE PLAN'S STEP THERAPY CRITERIA SHALL BE BASED
19 ON THE COVERED PERSON'S OR ENROLLEE'S INDIVIDUALIZED CLINICAL
20 CONDITION, AND CONSIDER AT LEAST ALL OF THE FOLLOWING:

21 (I) CONTRAINDICATIONS, INCLUDING ADVERSE REACTIONS.

22 (II) CLINICAL EFFECTIVENESS OR INEFFECTIVENESS OF
23 EACH REQUIRED PREREQUISITE PRESCRIPTION DRUG OR THERAPY.

24 (III) PAST CLINICAL OUTCOME OF EACH REQUIRED
25 PREREQUISITE PRESCRIPTION DRUG OR THERAPY.

26 (IV) THE EXPECTED CLINICAL OUTCOMES OF THE REQUESTED
27 PRESCRIPTION DRUG PRESCRIBED BY THE COVERED PERSON'S OR
28 ENROLLEE'S PROVIDER.

29 (V) FOR COVERED PERSONS OR ENROLLEES WHO PREVIOUSLY
30 RECEIVED HEALTH CARE COVERAGE FROM ANOTHER ENTITY,

1 WHETHER THE COVERED PERSON OR ENROLLEE HAS ALREADY
2 SATISFIED A STEP THERAPY PROTOCOL WITH THEIR PREVIOUS
3 INSURER OR MA OR CHIP MANAGED CARE PLAN THAT REQUIRED
4 TRIALS OF PRESCRIPTION DRUGS FROM EACH OF THE CLASSES
5 THAT ARE REQUIRED BY THE CURRENT INSURER'S OR MA OR CHIP
6 MANAGED CARE PLAN'S STEP THERAPY PROTOCOL.

7 (B) APPLICABILITY.--THE STANDARDS AND TIME LINES SPECIFIED
8 IN SECTION 2155 SHALL APPLY TO A REVIEW OF A REQUEST FOR A STEP
9 THERAPY EXCEPTION.

10 SECTION 2157. MEDICATION-ASSISTED TREATMENT.

11 (A) GENERAL RULE.--AN INSURER OR MA OR CHIP MANAGED CARE
12 PLAN SHALL MAKE AVAILABLE WITHOUT INITIAL PRIOR AUTHORIZATION
13 COVERAGE OF AT LEAST ONE PRESCRIPTION DRUG APPROVED BY THE
14 UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE IN EACH
15 COMPONENT OF A MEDICATION-ASSISTED TREATMENT PROTOCOL.

16 (B) PREFERRED DRUG DESIGNATION.--NOTHING IN THIS SECTION
17 SHALL PROHIBIT AN INSURER OR MA OR CHIP MANAGED CARE PLAN FROM
18 DESIGNATING PREFERRED DRUGS FOR THE RELEVANT COMPONENT OF A
19 MEDICATION-ASSISTED TREATMENT PROTOCOL WHEN MULTIPLE
20 PRESCRIPTION DRUGS ARE AVAILABLE, SUBJECT TO APPLICABLE MEDICAL
21 POLICY OR PRESCRIPTION DRUG FORMULARY INFORMATION AVAILABILITY
22 REQUIREMENTS.

23 (C) SUBSEQUENT REQUESTS.--WITH THE EXCEPTION OF PRIOR
24 AUTHORIZATION FOR INITIAL COVERAGE, NOTHING IN THIS SECTION
25 SHALL PROHIBIT AN INSURER OR MA OR CHIP MANAGED CARE PLAN FROM
26 REQUIRING PRIOR AUTHORIZATION ON SUBSEQUENT REQUESTS FOR
27 MEDICATION-ASSISTED TREATMENT TO ENSURE ADHERENCE WITH CLINICAL
28 GUIDELINES.

29 SECTION 6. SECTIONS 2161, 2162 AND 2163 OF THE ACT ARE
30 AMENDED TO READ:

1 SECTION 2161. INTERNAL GRIEVANCE PROCESS.-- (A) [A] AN MA OR
2 CHIP MANAGED CARE PLAN SHALL ESTABLISH AND MAINTAIN AN INTERNAL
3 GRIEVANCE PROCESS WITH TWO LEVELS OF REVIEW AND AN EXPEDITED
4 INTERNAL GRIEVANCE PROCESS BY WHICH AN ENROLLEE, AN ENROLLEE'S
5 AUTHORIZED REPRESENTATIVE OR A HEALTH CARE PROVIDER, WITH THE
6 WRITTEN CONSENT OF THE ENROLLEE, SHALL BE ABLE TO FILE A WRITTEN
7 GRIEVANCE REGARDING THE DENIAL OF PAYMENT FOR A HEALTH CARE
8 SERVICE. AN ENROLLEE OR AN ENROLLEE'S AUTHORIZED REPRESENTATIVE
9 WHO CONSENTS TO THE FILING OF A GRIEVANCE BY A HEALTH CARE
10 PROVIDER UNDER THIS SECTION MAY NOT FILE A SEPARATE GRIEVANCE.

11 (B) THE INTERNAL GRIEVANCE PROCESS SHALL CONSIST OF AN
12 INITIAL REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

13 (1) A REVIEW BY [ONE] THREE OR MORE PERSONS SELECTED BY THE
14 MA OR CHIP MANAGED CARE PLAN WHO DID NOT PREVIOUSLY PARTICIPATE
15 IN THE DECISION TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

16 (2) [THE COMPLETION OF THE REVIEW WITHIN THIRTY (30) DAYS OF
17 RECEIPT OF THE GRIEVANCE.] A WRITTEN NOTIFICATION TO THE
18 ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OF THE
19 DECISION OF THE REVIEW COMMITTEE WITHIN THIRTY (30) DAYS OF
20 RECEIPT OF THE GRIEVANCE UNLESS THE TIME FRAME FOR DECIDING THE
21 GRIEVANCE HAS BEEN EXTENDED BY UP TO FOURTEEN (14) DAYS AT THE
22 REQUEST OF THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED
23 REPRESENTATIVE.

24 (3) [A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE
25 PROVIDER REGARDING THE DECISION WITHIN FIVE (5) BUSINESS DAYS OF
26 THE DECISION.] THE NOTICE SHALL INCLUDE THE BASIS AND CLINICAL
27 RATIONALE FOR THE DECISION AND THE PROCEDURE [TO FILE A REQUEST
28 FOR A SECOND LEVEL REVIEW OF THE DECISION] FOR APPEALING THE
29 DECISION.

30 (C) [THE GRIEVANCE PROCESS SHALL INCLUDE A SECOND LEVEL

1 REVIEW THAT INCLUDES ALL OF THE FOLLOWING:

2 (1) A REVIEW OF THE DECISION ISSUED PURSUANT TO SUBSECTION
3 (B) BY A SECOND LEVEL REVIEW COMMITTEE CONSISTING OF THREE OR
4 MORE PERSONS WHO DID NOT PREVIOUSLY PARTICIPATE IN ANY DECISION
5 TO DENY PAYMENT FOR THE HEALTH CARE SERVICE.

6 (2) A WRITTEN NOTIFICATION TO THE ENROLLEE OR THE HEALTH
7 CARE PROVIDER OF THE RIGHT TO APPEAR BEFORE THE SECOND LEVEL
8 REVIEW COMMITTEE.

9 (3) THE COMPLETION OF THE SECOND LEVEL REVIEW WITHIN FORTY-
10 FIVE (45) DAYS OF RECEIPT OF A REQUEST FOR SUCH REVIEW.

11 (4) A WRITTEN NOTIFICATION TO THE ENROLLEE AND HEALTH CARE
12 PROVIDER REGARDING THE DECISION OF THE SECOND LEVEL REVIEW
13 COMMITTEE WITHIN FIVE (5) BUSINESS DAYS OF THE DECISION. THE
14 NOTICE SHALL INCLUDE THE BASIS AND CLINICAL RATIONALE FOR THE
15 DECISION AND THE PROCEDURE FOR APPEALING THE DECISION.

16 (D) ANY INITIAL REVIEW OR SECOND LEVEL REVIEW CONDUCTED
17 UNDER THIS SECTION SHALL INCLUDE A LICENSED PHYSICIAN, OR, WHERE
18 APPROPRIATE, AN APPROVED LICENSED PSYCHOLOGIST, IN THE SAME OR
19 SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS ON THE
20 HEALTH CARE SERVICE.] A REVIEW CONDUCTED UNDER THIS SECTION

21 SHALL INCLUDE A LICENSED PHYSICIAN OR, WHERE APPROPRIATE, AN
22 APPROVED LICENSED PSYCHOLOGIST OR APPROVED LICENSED DENTIST, IN
23 THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY MANAGES OR CONSULTS
24 ON THE HEALTH CARE SERVICE.

25 (E) SHOULD THE ENROLLEE'S LIFE, HEALTH OR ABILITY TO REGAIN
26 MAXIMUM FUNCTION BE IN JEOPARDY, AN EXPEDITED INTERNAL GRIEVANCE
27 PROCESS, INCLUDING AN EXPEDITED EXTERNAL GRIEVANCE PROCESS,
28 SHALL BE AVAILABLE WHICH SHALL INCLUDE A REQUIREMENT THAT A
29 DECISION WITH APPROPRIATE NOTIFICATION TO THE ENROLLEE AND
30 HEALTH CARE PROVIDER BE MADE WITHIN FORTY-EIGHT (48) HOURS OF

1 THE FILING OF THE EXPEDITED GRIEVANCE.

2 SECTION 2162. EXTERNAL GRIEVANCE PROCESS.-- (A) [A] AN MA OR
3 CHIP MANAGED CARE PLAN SHALL ESTABLISH AND MAINTAIN AN EXTERNAL
4 GRIEVANCE PROCESS, INCLUDING AN EXPEDITED GRIEVANCE PROCESS, BY
5 WHICH AN ENROLLEE, AN ENROLLEE'S AUTHORIZED REPRESENTATIVE OR A
6 HEALTH CARE PROVIDER WITH THE WRITTEN CONSENT OF THE ENROLLEE OR
7 THE ENROLLEE'S AUTHORIZED REPRESENTATIVE MAY APPEAL THE DENIAL
8 OF A GRIEVANCE FOLLOWING COMPLETION OF THE INTERNAL GRIEVANCE
9 PROCESS. THE EXTERNAL GRIEVANCE PROCESS SHALL BE CONDUCTED BY AN
10 INDEPENDENT UTILIZATION REVIEW ENTITY NOT DIRECTLY AFFILIATED
11 WITH THE MA OR CHIP MANAGED CARE PLAN.

12 (B) TO CONDUCT EXTERNAL GRIEVANCES FILED UNDER THIS SECTION:

13 (1) THE DEPARTMENT SHALL RANDOMLY ASSIGN [A UTILIZATION
14 REVIEW ENTITY] AN IRO ON A ROTATIONAL BASIS FROM THE LIST
15 MAINTAINED UNDER SUBSECTION (D) AND NOTIFY THE ASSIGNED
16 [UTILIZATION REVIEW ENTITY] IRO AND THE MA OR CHIP MANAGED CARE
17 PLAN WITHIN TWO (2) BUSINESS DAYS OF RECEIVING THE REQUEST. IF
18 THE DEPARTMENT FAILS TO SELECT [A UTILIZATION REVIEW ENTITY] AN
19 IRO UNDER THIS SUBSECTION, THE MA OR CHIP MANAGED CARE PLAN
20 SHALL DESIGNATE AND NOTIFY A CERTIFIED [UTILIZATION REVIEW
21 ENTITY] IRO TO CONDUCT THE EXTERNAL GRIEVANCE.

22 (2) THE MA OR CHIP MANAGED CARE PLAN SHALL NOTIFY THE
23 ENROLLEE, THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OR HEALTH
24 CARE PROVIDER OF THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE
25 [UTILIZATION REVIEW ENTITY] IRO ASSIGNED UNDER THIS SUBSECTION
26 WITHIN TWO (2) BUSINESS DAYS.

27 (C) THE EXTERNAL GRIEVANCE PROCESS SHALL MEET ALL OF THE
28 FOLLOWING REQUIREMENTS:

29 (1) ANY EXTERNAL GRIEVANCE SHALL BE FILED WITH THE MA OR
30 CHIP MANAGED CARE PLAN WITHIN FIFTEEN (15) DAYS OF RECEIPT OF A

1 NOTICE OF DENIAL RESULTING FROM THE INTERNAL GRIEVANCE PROCESS.
2 THE FILING OF THE EXTERNAL GRIEVANCE SHALL INCLUDE ANY MATERIAL
3 JUSTIFICATION AND ALL REASONABLY NECESSARY SUPPORTING
4 INFORMATION. WITHIN FIVE (5) BUSINESS DAYS OF THE FILING OF AN
5 EXTERNAL GRIEVANCE, THE MA OR CHIP MANAGED CARE PLAN SHALL
6 NOTIFY THE ENROLLEE, THE ENROLLEE'S AUTHORIZED REPRESENTATIVE OR
7 THE HEALTH CARE PROVIDER, THE [UTILIZATION REVIEW ENTITY] IRO
8 THAT CONDUCTED THE INTERNAL GRIEVANCE AND THE DEPARTMENT THAT AN
9 EXTERNAL GRIEVANCE HAS BEEN FILED.

10 (2) THE [UTILIZATION REVIEW ENTITY] IRO THAT CONDUCTED THE
11 INTERNAL GRIEVANCE SHALL FORWARD COPIES OF ALL WRITTEN
12 DOCUMENTATION REGARDING THE DENIAL, INCLUDING THE DECISION, ALL
13 REASONABLY NECESSARY SUPPORTING INFORMATION, A SUMMARY OF
14 APPLICABLE ISSUES AND THE BASIS AND CLINICAL RATIONALE FOR THE
15 DECISION, TO THE UTILIZATION REVIEW ENTITY CONDUCTING THE
16 EXTERNAL GRIEVANCE WITHIN FIFTEEN (15) DAYS OF RECEIPT OF NOTICE
17 THAT THE EXTERNAL GRIEVANCE WAS FILED. ANY ADDITIONAL WRITTEN
18 INFORMATION MAY BE SUBMITTED BY THE ENROLLEE, THE ENROLLEE'S
19 AUTHORIZED REPRESENTATIVE OR THE HEALTH CARE PROVIDER WITHIN
20 [FIFTEEN (15) DAYS OF RECEIPT OF NOTICE THAT THE EXTERNAL
21 GRIEVANCE WAS FILED] TWENTY (20) DAYS OF THE DATE THE IRO
22 ASSIGNMENT WAS MAILED TO THE ENROLLEE OR ENROLLEE'S
23 REPRESENTATIVE.

24 (3) THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE
25 EXTERNAL GRIEVANCE SHALL REVIEW ALL INFORMATION CONSIDERED IN
26 REACHING ANY PRIOR DECISIONS TO DENY PAYMENT FOR THE HEALTH CARE
27 SERVICE AND ANY OTHER WRITTEN SUBMISSION BY THE ENROLLEE, THE
28 ENROLLEE'S AUTHORIZED REPRESENTATIVE OR THE HEALTH CARE
29 PROVIDER.

30 (4) AN EXTERNAL GRIEVANCE DECISION SHALL BE MADE BY:

1 (I) ONE OR MORE LICENSED PHYSICIANS [OR], APPROVED LICENSED
2 PSYCHOLOGISTS OR APPROVED LICENSED DENTISTS IN ACTIVE CLINICAL
3 PRACTICE OR IN THE SAME OR SIMILAR SPECIALTY THAT TYPICALLY
4 MANAGES OR RECOMMENDS TREATMENT FOR THE HEALTH CARE SERVICE
5 BEING REVIEWED; OR

6 (II) ONE OR MORE PHYSICIANS CURRENTLY CERTIFIED BY A BOARD
7 APPROVED BY THE AMERICAN BOARD OF MEDICAL SPECIALISTS OR THE
8 AMERICAN BOARD OF OSTEOPATHIC SPECIALTIES IN THE SAME OR SIMILAR
9 SPECIALTY THAT TYPICALLY MANAGES OR RECOMMENDS TREATMENT FOR THE
10 HEALTH CARE SERVICE BEING REVIEWED.

11 (5) WITHIN SIXTY (60) DAYS OF THE FILING OF THE EXTERNAL
12 GRIEVANCE, THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE
13 EXTERNAL GRIEVANCE SHALL ISSUE A WRITTEN DECISION TO THE MA OR
14 CHIP MANAGED CARE PLAN, THE ENROLLEE, THE ENROLLEE'S AUTHORIZED
15 REPRESENTATIVE IF THE ENROLLEE'S AUTHORIZED REPRESENTATIVE
16 REQUESTED THE EXTERNAL REVIEW, AND THE HEALTH CARE PROVIDER,
17 INCLUDING THE BASIS AND CLINICAL RATIONALE FOR THE DECISION. THE
18 STANDARD OF REVIEW SHALL BE WHETHER THE HEALTH CARE SERVICE
19 DENIED BY THE INTERNAL GRIEVANCE PROCESS WAS MEDICALLY NECESSARY
20 AND APPROPRIATE UNDER THE TERMS OF THE MA OR CHIP MANAGED CARE
21 PLAN. THE EXTERNAL GRIEVANCE DECISION SHALL BE SUBJECT TO APPEAL
22 TO A COURT OF COMPETENT JURISDICTION WITHIN SIXTY (60) DAYS OF
23 RECEIPT OF NOTICE OF THE EXTERNAL GRIEVANCE DECISION. THERE
24 SHALL BE A REBUTTABLE PRESUMPTION IN FAVOR OF THE DECISION OF
25 THE [UTILIZATION REVIEW ENTITY] IRO CONDUCTING THE EXTERNAL
26 GRIEVANCE.

27 (6) THE MA OR CHIP MANAGED CARE PLAN SHALL AUTHORIZE ANY
28 HEALTH CARE SERVICE OR PAY A CLAIM DETERMINED TO BE MEDICALLY
29 NECESSARY AND APPROPRIATE UNDER PARAGRAPH (5) PURSUANT TO
30 SECTION 2166 WHETHER OR NOT AN APPEAL TO A COURT OF COMPETENT

1 JURISDICTION HAS BEEN FILED.

2 (7) ALL FEES AND COSTS RELATED TO AN EXTERNAL GRIEVANCE
3 SHALL BE PAID BY THE NONPREVAILING PARTY IF THE EXTERNAL
4 GRIEVANCE WAS FILED BY THE HEALTH CARE PROVIDER. THE HEALTH CARE
5 PROVIDER AND THE [UTILIZATION REVIEW ENTITY] IRO OR MA OR CHIP
6 MANAGED CARE PLAN SHALL EACH PLACE IN ESCROW AN AMOUNT EQUAL TO
7 ONE-HALF OF THE ESTIMATED COSTS OF THE EXTERNAL GRIEVANCE
8 PROCESS. IF THE EXTERNAL GRIEVANCE WAS FILED BY THE ENROLLEE OR
9 THE ENROLLEE'S AUTHORIZED REPRESENTATIVE, ALL FEES AND COSTS
10 RELATED THERETO SHALL BE PAID BY THE MA OR CHIP MANAGED CARE
11 PLAN. FOR PURPOSES OF THIS PARAGRAPH, FEES AND COSTS SHALL NOT
12 INCLUDE ATTORNEY FEES.

13 (D) THE DEPARTMENT SHALL COMPILE AND MAINTAIN A LIST OF
14 [CERTIFIED UTILIZATION REVIEW ENTITIES] IROS THAT MEET THE
15 REQUIREMENTS OF THIS ARTICLE. THE DEPARTMENT MAY REMOVE [A
16 UTILIZATION REVIEW ENTITY] AN IRO FROM THE LIST IF SUCH AN
17 ENTITY IS INCAPABLE OF PERFORMING ITS RESPONSIBILITIES IN A
18 REASONABLE MANNER, CHARGES EXCESSIVE FEES OR VIOLATES THIS
19 ARTICLE.

20 (E) A FEE MAY BE IMPOSED BY [A] AN MA OR CHIP MANAGED CARE
21 PLAN FOR FILING AN EXTERNAL GRIEVANCE PURSUANT TO THIS ARTICLE
22 WHICH SHALL NOT EXCEED TWENTY-FIVE (\$25) DOLLARS.

23 (F) WRITTEN CONTRACTS BETWEEN MA OR CHIP MANAGED CARE PLANS
24 AND HEALTH CARE PROVIDERS MAY PROVIDE AN ALTERNATIVE DISPUTE
25 RESOLUTION SYSTEM TO THE EXTERNAL GRIEVANCE PROCESS SET FORTH IN
26 THIS ARTICLE IF THE DEPARTMENT APPROVES THE CONTRACT. THE
27 ALTERNATIVE DISPUTE RESOLUTION SYSTEM SHALL BE IMPARTIAL,
28 INCLUDE SPECIFIC TIME LIMITATIONS TO INITIATE APPEALS, RECEIVE
29 WRITTEN INFORMATION, CONDUCT HEARINGS AND RENDER DECISIONS AND
30 OTHERWISE SATISFY THE REQUIREMENTS OF THIS SECTION. A WRITTEN

1 DECISION PURSUANT TO AN ALTERNATIVE DISPUTE RESOLUTION SYSTEM
2 SHALL BE FINAL AND BINDING ON ALL PARTIES. AN ALTERNATIVE
3 DISPUTE RESOLUTION SYSTEM SHALL NOT BE UTILIZED FOR ANY EXTERNAL
4 GRIEVANCE FILED BY AN ENROLLEE OR ENROLLEE'S AUTHORIZED
5 REPRESENTATIVE.

6 SECTION 2163. RECORDS.--RECORDS REGARDING GRIEVANCES FILED
7 UNDER THIS SUBDIVISION THAT RESULT IN DECISIONS ADVERSE TO
8 ENROLLEES SHALL BE MAINTAINED BY THE MA OR CHIP MANAGED CARE
9 PLAN FOR NOT LESS THAN THREE (3) YEARS. THESE RECORDS SHALL BE
10 PROVIDED TO THE DEPARTMENT, IF REQUESTED, IN ACCORDANCE WITH
11 SECTION 2131(C) (2) (II) .

12 SECTION 7. ARTICLE XXI OF THE ACT IS AMENDED BY ADDING A
13 SUBDIVISION TO READ:

14 (I.1) ADVERSE BENEFIT DETERMINATIONS.

15 SECTION 2164. INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS
16 FOR INSURER.

17 (A) DETERMINATION PROCESS.--AN INSURER SHALL ESTABLISH AND
18 MAINTAIN AN INTERNAL ADVERSE BENEFIT DETERMINATION PROCESS THAT
19 COMPLIES WITH SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT (58
20 STAT. 682, 42 U.S.C. § 300GG-19) AND REGULATIONS PROMULGATED
21 UNDER THE PUBLIC HEALTH SERVICE ACT.

22 (B) NOTICE.--FOLLOWING AN ADVERSE BENEFIT DETERMINATION AND
23 PRIOR TO ANY APPEAL OF AN ADVERSE BENEFIT DETERMINATION UNDER
24 SUBSECTION (A), AN INSURER SHALL PROVIDE A COVERED PERSON OR
25 COVERED PERSON'S AUTHORIZED REPRESENTATIVE NOTICE OF THE COVERED
26 PERSON'S RIGHT TO APPEAL AN ADVERSE BENEFIT DETERMINATION WHICH
27 SHALL BE IN A FORM APPROVED BY THE DEPARTMENT.

28 SECTION 2164.1. EXTERNAL REVIEW APPLICABILITY AND SCOPE.

29 (A) APPLICABILITY.--THE EXTERNAL REVIEW PROVISIONS OF THIS
30 SUBDIVISION SHALL APPLY TO:

1 (1) AN ADVERSE BENEFIT DETERMINATION RENDERED BY AN
2 INSURER THAT ARE BASED ON ANY OF THE FOLLOWING:

3 (I) MEDICAL NECESSITY.

4 (II) APPROPRIATENESS OF SERVICE.

5 (III) HEALTH CARE SETTING.

6 (IV) LEVEL OF CARE.

7 (V) EFFECTIVENESS OF A COVERED BENEFIT.

8 (2) (RESERVED) .

9 (B) NONAPPLICABILITY.--THE EXTERNAL REVIEW PROVISIONS OF
10 THIS SUBDIVISION DO NOT APPLY TO:

11 (1) COMPLAINTS, WHICH MAY BE APPEALED UNDER SECTION
12 2142.

13 (2) GRIEVANCES, WHICH MAY BE REVIEWED UNDER SECTION
14 2162.

15 (3) ADMINISTRATIVE ADVERSE BENEFIT DETERMINATIONS, WHICH
16 MAY BE APPEALED UNDER SECTION 2142.

17 (C) NO MINIMUM THRESHOLD.--THE EXTERNAL REVIEW PROCESS IS
18 AVAILABLE TO A COVERED PERSON OR COVERED PERSON'S AUTHORIZED
19 REPRESENTATIVE WITH RESPECT TO HEALTH CARE SERVICES OF ANY
20 MONETARY VALUE. THERE IS NO MINIMUM FINANCIAL THRESHOLD FOR
21 FILING A REQUEST FOR EXTERNAL REVIEW.

22 SECTION 2164.2. NOTICE OF RIGHT TO EXTERNAL REVIEW.

23 (A) TIMING OF NOTICE.--AN INSURER SHALL NOTIFY A COVERED
24 PERSON IN WRITING OF THE COVERED PERSON'S RIGHT TO REQUEST AN
25 EXTERNAL REVIEW UNDER SECTION 2164.5, 2164.6 OR 2164.7 AT THE
26 SAME TIME THE INSURER SENDS WRITTEN NOTICE IN A FORM APPROVED BY
27 THE DEPARTMENT OF EITHER OF THE FOLLOWING:

28 (1) AN ADVERSE BENEFIT DETERMINATION UPON COMPLETION OF
29 THE INSURER'S UTILIZATION REVIEW PROCESS.

30 (2) A FINAL ADVERSE BENEFIT DETERMINATION.

1 (B) CONTENT OF NOTICE.--THE NOTICE SHALL INCLUDE:

2 (1) THE FOLLOWING, OR SUBSTANTIALLY EQUIVALENT,
3 LANGUAGE:

4 WE HAVE DENIED YOUR REQUEST FOR THE PROVISION OF OR
5 PAYMENT FOR A HEALTH CARE SERVICE OR COURSE OF
6 TREATMENT. YOU MAY HAVE THE RIGHT TO HAVE OUR
7 DECISION REVIEWED BY HEALTH CARE PROVIDERS WHO HAVE
8 NO ASSOCIATION WITH US IF OUR DECISION INVOLVED
9 MAKING A JUDGMENT AS TO THE MEDICAL NECESSITY,
10 APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE
11 OR EFFECTIVENESS OF THE HEALTH CARE SERVICE OR
12 TREATMENT YOU REQUESTED. YOU ALSO HAVE THE RIGHT TO A
13 REVIEW OF WHETHER WE HAVE COMPLIED WITH THE SURPRISE
14 BILLING AND COST-SHARING PROTECTIONS UNDER THE NO
15 SURPRISES ACT. YOU MAY SUBMIT A REQUEST FOR EXTERNAL
16 REVIEW TO THE PENNSYLVANIA INSURANCE DEPARTMENT.

17 (2) FOR A NOTICE RELATED TO AN ADVERSE BENEFIT
18 DETERMINATION, A STATEMENT INFORMING THE COVERED PERSON THAT:

19 (I) IF THE COVERED PERSON HAS A MEDICAL CONDITION
20 FOR WHICH THE TIME FRAME FOR COMPLETION OF AN EXPEDITED
21 REVIEW OF AN ADVERSE BENEFIT DETERMINATION UNDER SECTION
22 2164 WOULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE
23 COVERED PERSON OR WOULD JEOPARDIZE THE COVERED PERSON'S
24 ABILITY TO REGAIN MAXIMUM FUNCTION, THE COVERED PERSON,
25 OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY
26 FILE A REQUEST FOR AN EXPEDITED EXTERNAL REVIEW AT THE
27 SAME TIME AS A REQUEST FOR AN EXPEDITED REVIEW OF AN
28 ADVERSE BENEFIT DETERMINATION UNDER SECTION 2164. THE IRO
29 ASSIGNED TO CONDUCT THE EXPEDITED EXTERNAL REVIEW SHALL
30 DETERMINE WHETHER THE COVERED PERSON IS REQUIRED TO

1 COMPLETE THE EXPEDITED REVIEW OF THE ADVERSE BENEFIT
2 DETERMINATION PRIOR TO CONDUCTING THE EXPEDITED EXTERNAL
3 REVIEW. THE REQUEST MAY BE FILED UNDER SECTION 2164.6 OR
4 2164.7 IF:

5 (A) THE ADVERSE BENEFIT DETERMINATION INVOLVES A
6 DENIAL OF COVERAGE BASED ON A DETERMINATION THAT THE
7 RECOMMENDED OR REQUESTED HEALTH CARE SERVICES ARE
8 EXPERIMENTAL OR INVESTIGATIONAL.

9 (B) THE COVERED PERSON'S TREATING HEALTH CARE
10 PROVIDER CERTIFIES IN WRITING THAT THE RECOMMENDED OR
11 REQUESTED HEALTH CARE SERVICES THAT ARE THE SUBJECT
12 OF THE ADVERSE BENEFIT DETERMINATION WOULD BE
13 SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY
14 INITIATED.

15 (II) THE COVERED PERSON OR THE COVERED PERSON'S
16 AUTHORIZED REPRESENTATIVE MAY FILE AN APPEAL UNDER THE
17 INSURER'S INTERNAL APPEAL PROCESS UNDER SECTION 2164, BUT
18 SHALL BE CONSIDERED TO HAVE EXHAUSTED THE INSURER'S
19 INTERNAL APPEAL PROCESS FOR PURPOSES OF SECTION 2164.4
20 AND MAY IMMEDIATELY FILE A REQUEST FOR EXTERNAL REVIEW
21 UNDER SECTION 2164.3 IF:

22 (A) THE INSURER HAS NOT ISSUED A WRITTEN
23 DECISION TO THE COVERED PERSON OR THE COVERED
24 PERSON'S AUTHORIZED REPRESENTATIVE WITHIN 30 DAYS
25 FOLLOWING THE DATE THE COVERED PERSON OR THE COVERED
26 PERSON'S AUTHORIZED REPRESENTATIVE FILES THE APPEAL
27 WITH THE INSURER.

28 (B) THE COVERED PERSON OR THE COVERED PERSON'S
29 AUTHORIZED REPRESENTATIVE HAS NOT REQUESTED OR AGREED
30 TO A DELAY.

1 (C) THE INSURER WAIVES ITS INTERNAL CLAIM AND
2 APPEAL PROCESS AND THE REQUIREMENT FOR A COVERED
3 PERSON OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE
4 TO EXHAUST THE PROCESS BEFORE FILING A REQUEST FOR AN
5 EXTERNAL REVIEW OR AN EXPEDITED EXTERNAL REVIEW.

6 (D) THE INSURER HAS FAILED TO COMPLY WITH THE
7 REQUIREMENTS OF THE INTERNAL CLAIM AND APPEAL PROCESS
8 UNLESS THE FAILURE OR FAILURES ARE BASED ON DE
9 MINIMIS VIOLATIONS THAT DO NOT CAUSE, AND ARE NOT
10 LIKELY TO CAUSE, PREJUDICE OR HARM TO THE COVERED
11 PERSON OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE.

12 (3) FOR A NOTICE RELATED TO A FINAL ADVERSE BENEFIT
13 DETERMINATION, A STATEMENT INFORMING THE COVERED PERSON THAT:

14 (I) IF THE COVERED PERSON HAS A MEDICAL CONDITION
15 FOR WHICH THE TIME FRAME FOR COMPLETION OF A STANDARD
16 EXTERNAL REVIEW UNDER SECTION 2164.5 WOULD SERIOUSLY
17 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR
18 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN
19 MAXIMUM FUNCTION, THE COVERED PERSON OR COVERED PERSON'S
20 AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST FOR AN
21 EXPEDITED EXTERNAL REVIEW UNDER SECTION 2164.6.

22 (II) IF THE FINAL ADVERSE BENEFIT DETERMINATION
23 CONCERNS:

24 (A) AN ADMISSION, AVAILABILITY OF CARE,
25 CONTINUED STAY OR HEALTH CARE SERVICE FOR WHICH THE
26 COVERED PERSON RECEIVED EMERGENCY SERVICES, BUT HAS
27 NOT BEEN DISCHARGED FROM A FACILITY, THE COVERED
28 PERSON OR THE COVERED PERSON'S AUTHORIZED
29 REPRESENTATIVE MAY REQUEST AN EXPEDITED EXTERNAL
30 REVIEW UNDER SECTION 2164.6.

1 (B) A DENIAL OF COVERAGE BASED ON A
2 DETERMINATION THAT THE RECOMMENDED OR REQUESTED
3 HEALTH CARE SERVICE IS EXPERIMENTAL OR
4 INVESTIGATIONAL, THE COVERED PERSON OR COVERED
5 PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST
6 FOR A STANDARD EXTERNAL REVIEW TO BE CONDUCTED UNDER
7 SECTION 2164.7.

8 (C) A WRITTEN CERTIFICATION BY THE TREATING
9 HEALTH CARE PROVIDER THAT THE RECOMMENDED OR
10 REQUESTED HEALTH CARE SERVICE THAT IS THE SUBJECT OF
11 THE REQUEST WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF
12 NOT PROMPTLY INITIATED, THE COVERED PERSON OR THE
13 COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY
14 REQUEST AN EXPEDITED EXTERNAL REVIEW TO BE CONDUCTED
15 UNDER SECTION 2164.7.

16 (4) A COPY OF THE DESCRIPTION OF BOTH THE STANDARD AND
17 EXPEDITED EXTERNAL REVIEW PROCEDURES REQUIRED BY SECTION
18 2136.1 THAT HIGHLIGHTS THE PROVISIONS IN THE EXTERNAL REVIEW
19 PROCEDURES REGARDING THE OPPORTUNITY TO SUBMIT ADDITIONAL
20 INFORMATION AND ANY FORMS USED TO PROCESS AN EXTERNAL REVIEW.

21 (5) AN AUTHORIZATION FORM, OR OTHER DOCUMENT APPROVED BY
22 THE DEPARTMENT THAT COMPLIES WITH THE REQUIREMENTS OF 45 CFR
23 164.508 (RELATING TO USES AND DISCLOSURES FOR WHICH AN
24 AUTHORIZATION IS REQUIRED), BY WHICH THE COVERED PERSON, FOR
25 PURPOSES OF CONDUCTING AN EXTERNAL REVIEW UNDER THIS
26 SUBDIVISION, AUTHORIZES THE INSURER AND THE COVERED PERSON'S
27 TREATING HEALTH CARE PROVIDER TO DISCLOSE PROTECTED HEALTH
28 INFORMATION, INCLUDING MEDICAL RECORDS, CONCERNING THE
29 COVERED PERSON, THAT ARE PERTINENT TO THE EXTERNAL REVIEW.
30 SECTION 2164.3. REQUEST FOR EXTERNAL REVIEW.

1 (A) FORM OF REQUEST.--

2 (1) EXCEPT FOR A REQUEST FOR AN EXPEDITED EXTERNAL
3 REVIEW UNDER SECTION 2164.6, A REQUEST FOR EXTERNAL REVIEW
4 SHALL BE MADE IN WRITING TO THE DEPARTMENT.

5 (2) THE DEPARTMENT MAY PRESCRIBE BY REGULATION THE FORM
6 AND CONTENT OF AN EXTERNAL REVIEW REQUEST REQUIRED TO BE
7 SUBMITTED UNDER THIS SECTION.

8 (B) PERMITTED REQUESTS.--A COVERED PERSON OR THE COVERED
9 PERSON'S AUTHORIZED REPRESENTATIVE MAY MAKE A REQUEST FOR AN
10 EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION OR FINAL
11 ADVERSE BENEFIT DETERMINATION.

12 SECTION 2164.4. EXHAUSTION OF INTERNAL APPEAL PROCESS.

13 (A) REQUIREMENT TO EXHAUST INTERNAL APPEAL PROCESS.--

14 (1) EXCEPT AS PROVIDED IN SUBSECTION (B), A REQUEST FOR
15 EXTERNAL REVIEW UNDER SECTION 2164.5, 2164.6 OR 2164.7 OR A
16 REQUEST FOR RETROSPECTIVE REVIEW UNDER SECTION 2164 MAY NOT
17 BE MADE UNTIL THE COVERED PERSON HAS EXHAUSTED THE INSURER'S
18 INTERNAL APPEAL PROCESS UNDER SECTION 2164.

19 (2) A COVERED PERSON IS CONSIDERED TO HAVE EXHAUSTED THE
20 INSURER'S INTERNAL APPEAL PROCESS FOR PURPOSES OF THIS
21 SECTION IF THE COVERED PERSON OR THE COVERED PERSON'S
22 AUTHORIZED REPRESENTATIVE:

23 (I) HAS FILED AN APPEAL INVOLVING AN ADVERSE BENEFIT
24 DETERMINATION UNDER SECTION 2164.

25 (II) EXCEPT TO THE EXTENT THE COVERED PERSON OR THE
26 COVERED PERSON'S AUTHORIZED REPRESENTATIVE REQUESTED OR
27 AGREED TO A DELAY, HAS NOT RECEIVED A WRITTEN DECISION ON
28 THE APPEAL FROM THE INSURER WITHIN 30 DAYS FOLLOWING THE
29 DATE THE COVERED PERSON OR THE COVERED PERSON'S
30 AUTHORIZED REPRESENTATIVE FILED THE APPEAL WITH THE

1 INSURER.

2 (III) THE INSURER WAIVES ITS INTERNAL CLAIM AND
3 APPEAL PROCESS AND THE REQUIREMENT FOR A COVERED PERSON
4 OR COVERED PERSON'S AUTHORIZED REPRESENTATIVE TO EXHAUST
5 THE PROCESS BEFORE FILING A REQUEST FOR AN EXTERNAL
6 REVIEW OR AN EXPEDITED EXTERNAL REVIEW.

7 (IV) THE INSURER HAS FAILED TO COMPLY WITH THE
8 REQUIREMENTS OF THE INTERNAL CLAIM AND APPEAL PROCESS
9 UNLESS THE FAILURE OR FAILURES ARE BASED ON DE MINIMIS
10 VIOLATIONS THAT DO NOT CAUSE, AND ARE NOT LIKELY TO
11 CAUSE, PREJUDICE OR HARM TO THE COVERED PERSON OR COVERED
12 PERSON'S AUTHORIZED REPRESENTATIVE.

13 (B) PROCEDURE FOR REQUESTING EXPEDITED EXTERNAL REVIEW.--

14 (1) AT THE SAME TIME A COVERED PERSON OR THE COVERED
15 PERSON'S AUTHORIZED REPRESENTATIVE FILES A REQUEST FOR
16 EXPEDITED INTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION
17 UNDER SECTION 2164, THE COVERED PERSON OR THE COVERED
18 PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A REQUEST FOR AN
19 EXPEDITED EXTERNAL REVIEW OF THE ADVERSE BENEFIT
20 DETERMINATION:

21 (I) UNDER SECTION 2164.6, IF THE COVERED PERSON HAS
22 A MEDICAL CONDITION FOR WHICH THE TIME FRAME FOR
23 COMPLETION OF AN EXPEDITED INTERNAL REVIEW OF THE ADVERSE
24 BENEFIT DETERMINATION UNDER SECTION 2164 WOULD SERIOUSLY
25 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR
26 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN
27 MAXIMUM FUNCTION.

28 (II) UNDER SECTION 2164.7, IF THE ADVERSE BENEFIT
29 DETERMINATION INVOLVES A DENIAL OF COVERAGE BASED ON A
30 DETERMINATION THAT THE RECOMMENDED OR REQUESTED HEALTH

1 CARE SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL, AND THE
2 COVERED PERSON'S TREATING HEALTH CARE PROVIDER CERTIFIES
3 IN WRITING THAT THE RECOMMENDED OR REQUESTED HEALTH CARE
4 SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT
5 DETERMINATION WOULD BE SIGNIFICANTLY LESS EFFECTIVE IF
6 NOT PROMPTLY INITIATED.

7 (2) UPON RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL
8 REVIEW UNDER PARAGRAPH (1), THE IRO CONDUCTING THE EXTERNAL
9 REVIEW UNDER SECTION 2164.6 OR SECTION 2164.7 SHALL DETERMINE
10 WHETHER THE COVERED PERSON IS REQUIRED TO COMPLETE THE
11 EXPEDITED INTERNAL REVIEW PROCESS UNDER SECTION 2164 BEFORE
12 THE IRO CONDUCTS THE EXPEDITED EXTERNAL REVIEW.

13 (C) DENIAL OF REQUEST FOR EXPEDITED EXTERNAL REVIEW.--IF THE
14 IRO DETERMINES THAT THE COVERED PERSON IS REQUIRED TO FIRST
15 COMPLETE THE INTERNAL EXPEDITED APPEAL PROCESS UNDER SECTION
16 2164, THE IRO SHALL WITHIN 24 HOURS NOTIFY THE COVERED PERSON
17 AND, IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
18 REPRESENTATIVE, THAT THE IRO MAY NOT PROCEED WITH THE EXPEDITED
19 EXTERNAL REVIEW UNDER SECTION 2164.6 UNTIL THE INSURER HAS
20 COMPLETED THE EXPEDITED REVIEW PROCESS AND THE COVERED PERSON'S
21 ADVERSE BENEFIT DETERMINATION APPEAL REMAINS UNRESOLVED.

22 (D) WAIVER OF EXHAUSTION REQUIREMENT.--A REQUEST FOR
23 EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION MAY BE MADE
24 BEFORE THE COVERED PERSON HAS EXHAUSTED THE INSURER'S INTERNAL
25 APPEAL PROCEDURES UNDER SECTION 2164, IF THE INSURER AGREES TO
26 WAIVE THE EXHAUSTION REQUIREMENT. AT THAT TIME, THE COVERED
27 PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY
28 FILE A REQUEST IN WRITING FOR STANDARD EXTERNAL REVIEW AS
29 PROVIDED IN SECTION 2164.5 OR SECTION 2164.7.
30 SECTION 2164.5. STANDARD EXTERNAL REVIEW.

1 (A) REQUEST FOR REVIEW.--

2 (1) A COVERED PERSON, OR THE COVERED PERSON'S AUTHORIZED
3 REPRESENTATIVE, MAY FILE A REQUEST FOR EXTERNAL REVIEW WITH
4 THE DEPARTMENT WITHIN FOUR MONTHS AFTER THE DATE OF RECEIPT
5 OF A NOTICE OF AN ADVERSE BENEFIT DETERMINATION OR FINAL
6 ADVERSE BENEFIT DETERMINATION UNDER SECTION 2164.2.

7 (2) THE DEPARTMENT SHALL SEND A COPY OF THE REQUEST TO
8 THE INSURER WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF
9 A REQUEST FOR EXTERNAL REVIEW UNDER PARAGRAPH (1).

10 (B) PRELIMINARY REVIEW OF REQUEST.--WITHIN FIVE BUSINESS
11 DAYS OF THE DATE OF RECEIPT OF THE COPY OF THE EXTERNAL REVIEW
12 REQUEST RECEIVED UNDER SUBSECTION (A) (2), THE INSURER SHALL
13 COMPLETE A PRELIMINARY REVIEW OF THE REQUEST TO DETERMINE
14 WHETHER:

15 (1) THE INDIVIDUAL IS OR WAS A COVERED PERSON UNDER THE
16 HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE SERVICE
17 WAS REQUESTED OR, IN THE CASE OF A RETROSPECTIVE REVIEW, WAS
18 A COVERED PERSON UNDER THE HEALTH INSURANCE POLICY AT THE
19 TIME THE HEALTH CARE SERVICE WAS PROVIDED.

20 (2) THE HEALTH CARE SERVICE THAT IS THE SUBJECT OF THE
21 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT
22 DETERMINATION IS A COVERED SERVICE UNDER THE COVERED PERSON'S
23 HEALTH INSURANCE POLICY, EXCEPT FOR A DETERMINATION BY THE
24 INSURER THAT THE HEALTH CARE SERVICE IS NOT COVERED BECAUSE
25 IT DOES NOT MEET THE INSURER'S REQUIREMENTS FOR MEDICAL
26 NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF
27 CARE OR EFFECTIVENESS.

28 (3) THE COVERED PERSON HAS EXHAUSTED THE INSURER'S
29 INTERNAL APPEAL PROCESS UNDER SECTION 2164, UNLESS THE
30 COVERED PERSON IS NOT REQUIRED TO EXHAUST THE INSURER'S

1 INTERNAL APPEAL PROCESS UNDER SECTION 2164.4.

2 (4) THE COVERED PERSON HAS NOT PROVIDED ALL THE
3 INFORMATION AND FORMS REQUIRED TO PROCESS AN EXTERNAL REVIEW,
4 INCLUDING THE RELEASE FORM PROVIDED UNDER SECTION 2164.2(B).
5 (C) NOTICE OF INITIAL DETERMINATION.--

6 (1) WITHIN ONE BUSINESS DAY OF COMPLETION OF THE
7 PRELIMINARY REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT
8 AND THE COVERED PERSON AND, IF APPLICABLE, THE COVERED
9 PERSON'S AUTHORIZED REPRESENTATIVE, IN WRITING WHETHER THE
10 REQUEST IS COMPLETE AND ELIGIBLE FOR EXTERNAL REVIEW. THE
11 FOLLOWING APPLY:

12 (I) IF THE REQUEST IS NOT COMPLETE, THE INSURER
13 SHALL INFORM THE COVERED PERSON AND, IF APPLICABLE, THE
14 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, AND THE
15 DEPARTMENT IN WRITING AND INCLUDE IN THE NOTICE WHAT
16 INFORMATION OR MATERIALS ARE NEEDED TO MAKE THE REQUEST
17 COMPLETE.

18 (II) IF THE REQUEST IS NOT ELIGIBLE FOR EXTERNAL
19 REVIEW, THE INSURER SHALL INFORM THE COVERED PERSON AND,
20 IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
21 REPRESENTATIVE, AND THE DEPARTMENT IN WRITING AND INCLUDE
22 IN THE NOTICE THE REASONS FOR THE REQUEST'S
23 INELIGIBILITY.

24 (2) NOTIFICATION UNDER PARAGRAPH (1)(II) SHALL BE
25 PROVIDED IN A FORM AS SPECIFIED BY THE DEPARTMENT AND INCLUDE
26 A STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,
27 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE THAT AN
28 INSURER'S INITIAL DETERMINATION THAT THE EXTERNAL REVIEW
29 REQUEST IS INELIGIBLE FOR REVIEW MAY BE APPEALED TO THE
30 DEPARTMENT.

1 (3) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION
2 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY
3 DETERMINE, BASED UPON THE TERMS OF THE COVERED PERSON'S
4 HEALTH INSURANCE POLICY, THAT A REQUEST IS ELIGIBLE FOR
5 EXTERNAL REVIEW UNDER SUBSECTION (B). THE DETERMINATION SHALL
6 BE BINDING ON THE INSURER AND THE COVERED PERSON AND MAY BE
7 APPEALED TO THE COMMISSIONER. CONSIDERATION OF THE APPEAL MAY
8 NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

9 (D) PROCEDURE FOR REVIEW OF ELIGIBLE REQUESTS.--

10 (1) WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF
11 NOTICE THAT A REQUEST IS ELIGIBLE FOR EXTERNAL REVIEW
12 FOLLOWING THE PRELIMINARY REVIEW CONDUCTED UNDER SUBSECTION
13 (C), THE DEPARTMENT SHALL:

14 (I) ASSIGN AN IRO TO CONDUCT THE EXTERNAL REVIEW
15 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY
16 THE DEPARTMENT UNDER SECTION 2164.9 AND NOTIFY THE
17 INSURER OF THE NAME OF THE ASSIGNED IRO.

18 (II) NOTIFY IN WRITING THE COVERED PERSON AND, IF
19 APPLICABLE, THE COVERED PERSON'S AUTHORIZED
20 REPRESENTATIVE, OF THE REQUEST'S ELIGIBILITY AND
21 ACCEPTANCE FOR EXTERNAL REVIEW. THE NOTIFICATION SHALL
22 INCLUDE A STATEMENT THAT THE COVERED PERSON, OR THE
23 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY SUBMIT IN
24 WRITING TO THE ASSIGNED IRO, WITHIN 15 BUSINESS DAYS OF
25 THE DATE OF RECEIPT OF THE NOTICE PROVIDED UNDER
26 SUBPARAGRAPH (I), ADDITIONAL INFORMATION THAT THE IRO
27 SHALL CONSIDER WHEN CONDUCTING THE EXTERNAL REVIEW. THE
28 IRO MAY ACCEPT AND CONSIDER ADDITIONAL INFORMATION
29 SUBMITTED AFTER FIVE BUSINESS DAYS.

30 (2) THE ASSIGNED IRO SHALL NOT BE BOUND BY A DECISION OR

1 CONCLUSION REACHED DURING THE INSURER'S INTERNAL CLAIMS AND
2 APPEAL PROCESS UNDER SECTION 2164.

3 (E) FORWARDING OF REQUIRED DOCUMENTS.--

4 (1) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF
5 THE NOTICE PROVIDED UNDER SUBSECTION (D) (1), THE INSURER, OR
6 A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY THE INSURER,
7 SHALL PROVIDE TO THE ASSIGNED IRO THE DOCUMENTS AND
8 INFORMATION CONSIDERED IN MAKING THE ADVERSE BENEFIT
9 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION.

10 (2) IF THE INSURER, OR A UTILIZATION REVIEW ORGANIZATION
11 DESIGNATED BY THE INSURER, FAILS TO PROVIDE DOCUMENTS AND
12 INFORMATION WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH
13 (1), THE IRO MAY PROCEED WITH THE REVIEW, TERMINATE THE
14 EXTERNAL REVIEW AND MAKE A DECISION TO REVERSE THE ADVERSE
15 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION.
16 WITHIN ONE BUSINESS DAY OF MAKING THE DECISION UNDER
17 PARAGRAPH (1), THE IRO SHALL NOTIFY THE DEPARTMENT, THE
18 INSURER, THE COVERED PERSON AND, IF APPLICABLE, THE COVERED
19 PERSON'S AUTHORIZED REPRESENTATIVE.

20 (F) REVIEW OF INFORMATION.--

21 (1) THE ASSIGNED IRO SHALL REVIEW ALL OF THE INFORMATION
22 AND DOCUMENTS RECEIVED UNDER SUBSECTION (E) AND OTHER
23 INFORMATION SUBMITTED IN WRITING TO THE IRO BY THE COVERED
24 PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE
25 UNDER SUBSECTION (D) (1) (II).

26 (2) WITHIN ONE BUSINESS DAY OF RECEIPT OF INFORMATION
27 SUBMITTED BY THE COVERED PERSON OR THE COVERED PERSON'S
28 AUTHORIZED REPRESENTATIVE, THE ASSIGNED IRO SHALL FORWARD THE
29 INFORMATION TO THE INSURER.

30 (G) RECONSIDERATION BY INSURER.--

1 (1) UPON RECEIPT OF THE INFORMATION, IF ANY, REQUIRED TO
2 BE FORWARDED UNDER SUBSECTION (F) (2), THE INSURER MAY
3 RECONSIDER AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE
4 BENEFIT DETERMINATION THAT IS THE SUBJECT OF THE EXTERNAL
5 REVIEW.

6 (2) RECONSIDERATION BY THE INSURER OF AN ADVERSE BENEFIT
7 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION UNDER
8 PARAGRAPH (1) MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

9 (3) THE EXTERNAL REVIEW MAY BE TERMINATED WITHOUT AN IRO
10 DETERMINATION ONLY IF THE INSURER DECIDES, UPON COMPLETION OF
11 THE INSURER'S RECONSIDERATION, TO REVERSE THE INSURER'S
12 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
13 DETERMINATION AND PROVIDE COVERAGE OR PAYMENT FOR THE
14 RECOMMENDED HEALTH CARE SERVICE THAT IS THE SUBJECT OF THE
15 EXTERNAL REVIEW.

16 (4) WITHIN ONE BUSINESS DAY OF MAKING THE DECISION TO
17 REVERSE ITS ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE
18 BENEFIT DETERMINATION, AS PROVIDED IN PARAGRAPH (3), THE
19 INSURER SHALL NOTIFY THE DEPARTMENT, THE ASSIGNED IRO, THE
20 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S
21 AUTHORIZED REPRESENTATIVE, IN WRITING OF ITS DECISION.

22 (5) THE ASSIGNED IRO SHALL TERMINATE THE EXTERNAL REVIEW
23 UPON RECEIPT OF THE NOTICE FROM THE INSURER SENT UNDER
24 PARAGRAPH (4).

25 (H) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS
26 AND INFORMATION PROVIDED UNDER SUBSECTION (E), THE ASSIGNED IRO,
27 TO THE EXTENT THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE
28 IRO CONSIDERS THEM APPROPRIATE, SHALL CONSIDER THE FOLLOWING
29 INFORMATION IN REACHING A DECISION:

30 (1) THE COVERED PERSON'S MEDICAL RECORDS.

1 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

2 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE
3 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE
4 COVERED PERSON, THE COVERED PERSON'S AUTHORIZED
5 REPRESENTATIVE OR THE COVERED PERSON'S TREATING PROVIDER.

6 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S
7 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS
8 NOT CONTRARY TO THE TERMS OF COVERAGE.

9 (5) THE MOST APPROPRIATE PRACTICE GUIDELINES, WHICH
10 SHALL INCLUDE APPLICABLE EVIDENCE-BASED STANDARDS AND MAY
11 INCLUDE OTHER PRACTICE GUIDELINES DEVELOPED BY THE FEDERAL
12 GOVERNMENT OR NATIONAL OR PROFESSIONAL MEDICAL SOCIETIES,
13 BOARDS AND ASSOCIATIONS.

14 (6) APPLICABLE CLINICAL REVIEW CRITERIA DEVELOPED AND
15 USED BY THE INSURER OR A UTILIZATION REVIEW ORGANIZATION
16 DESIGNATED BY THE INSURER.

17 (7) THE OPTION OPINION OF THE IRO'S CLINICAL REVIEWER OR
18 REVIEWERS AFTER CONSIDERING THE INFORMATION UNDER PARAGRAPHS
19 (1), (2), (3), (4), (5) AND (6).

20 (I) NOTICE OF DECISION.--

21 (1) WITHIN 45 DAYS OF THE DATE OF RECEIPT OF THE REQUEST
22 FOR AN EXTERNAL REVIEW, THE ASSIGNED IRO SHALL PROVIDE
23 WRITTEN NOTICE OF THE IRO'S DECISION TO UPHOLD OR REVERSE THE
24 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT
25 DETERMINATION TO:

26 (I) THE COVERED PERSON.

27 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
28 REPRESENTATIVE.

29 (III) THE INSURER.

30 (IV) THE DEPARTMENT.

1 (2) THE IRO SHALL INCLUDE IN THE NOTICE UNDER PARAGRAPH
2 (1):
3 (I) A GENERAL DESCRIPTION OF THE REASON FOR THE
4 REQUEST FOR EXTERNAL REVIEW.
5 (II) THE DATE THE IRO RECEIVED THE ASSIGNMENT FROM
6 THE DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.
7 (III) THE DATE THE EXTERNAL REVIEW WAS CONDUCTED.
8 (IV) THE DATE OF THE IRO'S DECISION.
9 (V) THE PRINCIPAL REASON OR REASONS FOR THE IRO'S
10 DECISION, INCLUDING WHAT APPLICABLE EVIDENCE-BASED
11 STANDARDS WERE CONSIDERED IN REACHING THE IRO'S DECISION.
12 (VI) THE RATIONALE FOR THE IRO'S DECISION.
13 (VII) REFERENCES TO THE EVIDENCE OR DOCUMENTATION,
14 INCLUDING EVIDENCE-BASED STANDARDS, CONSIDERED IN
15 REACHING THE IRO'S DECISION.
16 (3) UPON RECEIPT OF A NOTICE OF A DECISION UNDER
17 PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR
18 FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL WITHIN
19 24 HOURS APPROVE THE COVERAGE THAT WAS THE SUBJECT OF THE
20 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
21 DETERMINATION.
22 (J) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN ON A
23 RANDOM BASIS AN APPROVED IRO FROM THOSE QUALIFIED TO CONDUCT THE
24 PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH
25 CARE SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT
26 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL
27 CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION
28 2164.10 (D).
29 SECTION 2164.6. EXPEDITED EXTERNAL REVIEW.
30 (A) REQUEST FOR REVIEW.--EXCEPT AS PROVIDED IN SUBSECTION

1 (F), A COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED
2 REPRESENTATIVE MAY MAKE A REQUEST FOR EXPEDITED EXTERNAL REVIEW
3 WITH THE DEPARTMENT AT THE TIME THE COVERED PERSON RECEIVES:

4 (1) AN ADVERSE BENEFIT DETERMINATION, IF EITHER OF THE
5 FOLLOWING APPLIES:

6 (I) THE ADVERSE BENEFIT DETERMINATION INVOLVES A
7 MEDICAL CONDITION OF THE COVERED PERSON FOR WHICH THE
8 TIME FRAME FOR COMPLETION OF AN EXPEDITED INTERNAL REVIEW
9 UNDER SECTION 2164 WOULD SERIOUSLY JEOPARDIZE THE LIFE OR
10 HEALTH OF THE COVERED PERSON OR WOULD JEOPARDIZE THE
11 COVERED PERSON'S ABILITY TO REGAIN MAXIMUM FUNCTION.

12 (II) THE COVERED PERSON OR THE COVERED PERSON'S
13 AUTHORIZED REPRESENTATIVE HAS FILED A REQUEST FOR AN
14 EXPEDITED INTERNAL REVIEW OF AN ADVERSE BENEFIT
15 DETERMINATION UNDER SECTION 2164.

16 (2) A FINAL ADVERSE BENEFIT DETERMINATION IF EITHER OF
17 THE FOLLOWING APPLY:

18 (I) THE COVERED PERSON HAS A MEDICAL CONDITION FOR
19 WHICH THE TIME FRAME FOR COMPLETION OF A STANDARD
20 EXTERNAL REVIEW UNDER SECTION 2164.5 WOULD SERIOUSLY
21 JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR
22 WOULD JEOPARDIZE THE COVERED PERSON'S ABILITY TO REGAIN
23 MAXIMUM FUNCTION.

24 (II) THE FINAL ADVERSE BENEFIT DETERMINATION
25 CONCERNS AN ADMISSION, AVAILABILITY OF CARE, CONTINUED
26 STAY OR HEALTH CARE SERVICE FOR WHICH THE COVERED PERSON
27 RECEIVED EMERGENCY SERVICES BUT HAS NOT BEEN DISCHARGED
28 FROM A FACILITY.

29 (B) PRELIMINARY REVIEW OF REQUEST.--

30 (1) UPON RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL

1 REVIEW, THE DEPARTMENT SHALL, WITHIN 24 HOURS, SEND A COPY OF
2 THE REQUEST TO THE INSURER.

3 (2) WITHIN 24 HOURS UPON RECEIPT OF A REQUEST UNDER
4 PARAGRAPH (1), THE INSURER SHALL DETERMINE WHETHER THE
5 REQUEST MEETS THE REQUIREMENTS FOR REVIEW UNDER SECTION
6 2164.5(B). THE INSURER SHALL, WITHIN 24 HOURS, NOTIFY THE
7 DEPARTMENT, THE COVERED PERSON AND, IF APPLICABLE, THE
8 COVERED PERSON'S AUTHORIZED REPRESENTATIVE OF THE INSURER'S
9 ELIGIBILITY DETERMINATION.

10 (3) NOTIFICATION PROVIDED UNDER PARAGRAPH (2) SHALL BE
11 PROVIDED IN A FORM AS SPECIFIED BY THE DEPARTMENT AND INCLUDE
12 A STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,
13 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE THAT AN
14 INSURER'S INITIAL DETERMINATION THAT THE EXTERNAL REVIEW
15 REQUEST IS INELIGIBLE FOR REVIEW MAY BE APPEALED TO THE
16 DEPARTMENT.

17 (4) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION
18 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY
19 DECIDE, BASED UPON THE TERMS OF THE COVERED PERSON'S HEALTH
20 INSURANCE POLICY, THAT A REQUEST IS ELIGIBLE FOR EXTERNAL
21 REVIEW UNDER SECTION 2164.5(B). THE DEPARTMENT'S DECISION
22 SHALL BE BINDING ON THE INSURER AND THE COVERED PERSON AND
23 MAY BE APPEALED TO THE COMMISSIONER. CONSIDERATION OF AN
24 APPEAL MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

25 (5) UPON RECEIPT OF THE NOTICE THAT THE REQUEST MEETS
26 THE REQUIREMENTS FOR REVIEW, THE DEPARTMENT SHALL, WITHIN 24
27 HOURS, ASSIGN AN IRO TO CONDUCT THE EXPEDITED EXTERNAL REVIEW
28 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY THE
29 DEPARTMENT UNDER SECTION 2164.9. THE DEPARTMENT SHALL, WITHIN
30 24 HOURS, NOTIFY THE INSURER OF THE NAME OF THE ASSIGNED IRO.

1 (6) IN REACHING A DECISION IN ACCORDANCE WITH SUBSECTION
2 (E), THE ASSIGNED IRO SHALL NOT BE BOUND BY A DECISION OR
3 CONCLUSION REACHED DURING THE INTERNAL ADVERSE BENEFIT
4 DETERMINATION PROCESS FOR AN INSURER UNDER SECTION 2164.

5 (C) FORWARDING OF REQUIRED DOCUMENTS.--UPON RECEIPT OF
6 DEPARTMENTAL NOTICE OF THE NAME OF THE IRO ASSIGNED TO CONDUCT
7 THE EXPEDITED EXTERNAL REVIEW UNDER SUBSECTION (B) (5), THE
8 INSURER OR AN IRO DESIGNATED BY THE INSURER SHALL PROVIDE TO THE
9 ASSIGNED IRO THE DOCUMENTS AND INFORMATION CONSIDERED IN MAKING
10 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
11 DETERMINATION BY ONE OF THE FOLLOWING METHODS:

12 (1) ELECTRONICALLY.

13 (2) BY TELEPHONE.

14 (3) BY FACSIMILE.

15 (4) BY ANY OTHER AVAILABLE EXPEDITIOUS METHOD.

16 (D) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS
17 AND INFORMATION PROVIDED UNDER SUBSECTION (C), THE ASSIGNED IRO,
18 TO THE EXTENT THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE
19 IRO CONSIDERS THEM APPROPRIATE, SHALL CONSIDER THE FOLLOWING
20 INFORMATION IN REACHING A DECISION:

21 (1) THE COVERED PERSON'S MEDICAL RECORDS.

22 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

23 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE
24 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE
25 COVERED PERSON, THE COVERED PERSON'S AUTHORIZED
26 REPRESENTATIVE OR THE COVERED PERSON'S TREATING PROVIDER.

27 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S
28 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS
29 NOT CONTRARY TO THE TERMS OF COVERAGE.

30 (5) THE MOST APPROPRIATE PRACTICE GUIDELINES, WHICH

1 SHALL INCLUDE APPLICABLE EVIDENCE-BASED STANDARDS AND MAY
2 INCLUDE ANY OTHER PRACTICE GUIDELINES DEVELOPED BY THE
3 FEDERAL GOVERNMENT OR NATIONAL OR PROFESSIONAL MEDICAL
4 SOCIETIES, BOARDS AND ASSOCIATIONS.

5 (6) APPLICABLE CLINICAL REVIEW CRITERIA DEVELOPED AND
6 USED BY THE INSURER OR A UTILIZATION REVIEW ORGANIZATION
7 DESIGNATED BY THE INSURER.

8 (7) THE OPINION OF THE IRO'S CLINICAL REVIEWER OR
9 REVIEWERS AFTER CONSIDERING THE INFORMATION UNDER PARAGRAPHS
10 (1), (2), (3), (4), (5) AND (6).

11 (E) NOTICE OF DECISION.--

12 (1) AS EXPEDITIOUSLY AS THE COVERED PERSON'S MEDICAL
13 CONDITION OR CIRCUMSTANCES REQUIRE, BUT IN NO EVENT MORE THAN
14 72 HOURS AFTER THE DATE OF RECEIPT OF THE REQUEST FOR AN
15 EXPEDITED EXTERNAL REVIEW THAT MEETS THE REVIEWABILITY
16 REQUIREMENTS UNDER SECTION 2164.5(B), THE ASSIGNED IRO SHALL
17 PROVIDE NOTICE OF THE IRO'S DECISION TO UPHOLD OR REVERSE THE
18 ADVERSE BENEFIT DETERMINATION OR THE FINAL ADVERSE BENEFIT
19 DETERMINATION TO:

20 (I) THE COVERED PERSON.

21 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
22 REPRESENTATIVE.

23 (III) THE INSURER.

24 (IV) THE DEPARTMENT.

25 (2) IF THE NOTICE PROVIDED UNDER PARAGRAPH (1) IS NOT IN
26 WRITING, WITHIN 48 HOURS OF THE DATE OF PROVIDING THAT
27 NOTICE, THE ASSIGNED IRO SHALL PROVIDE WRITTEN NOTICE OF THE
28 IRO'S DECISION TO UPHOLD OR REVERSE THE ADVERSE BENEFIT
29 DETERMINATION OR THE FINAL ADVERSE BENEFIT DETERMINATION TO:

30 (I) THE COVERED PERSON.

1 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
2 REPRESENTATIVE.

3 (III) THE INSURER.

4 (IV) THE DEPARTMENT.

5 (3) THE IRO SHALL INCLUDE IN THE NOTICE UNDER PARAGRAPH
6 (2):

7 (I) A GENERAL DESCRIPTION OF THE REASON FOR THE
8 REQUEST FOR EXTERNAL REVIEW.

9 (II) THE DATE THE IRO RECEIVED THE ASSIGNMENT FROM
10 THE DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.

11 (III) THE DATE THE EXTERNAL REVIEW WAS CONDUCTED.

12 (IV) THE DATE OF THE IRO'S DECISION.

13 (V) THE PRINCIPAL REASON OR REASON FOR THE IRO'S
14 DECISION, INCLUDING APPLICABLE EVIDENCE-BASED STANDARDS
15 CONSIDERED IN REACHING THE IRO'S DECISION.

16 (VI) THE RATIONALE FOR THE IRO'S DECISION.

17 (VII) REFERENCES TO THE EVIDENCE OR DOCUMENTATION,
18 INCLUDING EVIDENCE-BASED STANDARDS, CONSIDERED IN
19 REACHING THE IRO'S DECISION.

20 (4) UPON RECEIPT OF A NOTICE OF A DECISION UNDER
21 PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR
22 FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL,
23 WITHIN 24 HOURS, APPROVE THE COVERAGE THAT WAS THE SUBJECT OF
24 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
25 DETERMINATION.

26 (F) PROHIBITION OF RETROSPECTIVE EXPEDITED EXTERNAL
27 REVIEW.--AN EXPEDITED EXTERNAL REVIEW MAY NOT BE PROVIDED FOR
28 RETROSPECTIVE ADVERSE OR FINAL ADVERSE BENEFIT DETERMINATIONS.

29 (G) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN ON A
30 RANDOM BASIS AN APPROVED IRO AMONG THOSE QUALIFIED TO CONDUCT

1 THE PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH
2 CARE SERVICE THAT IS SUBJECT OF THE ADVERSE BENEFIT
3 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL
4 CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION
5 2164.10(D).

6 SECTION 2164.7. EXTERNAL REVIEW OF EXPERIMENTAL OR
7 INVESTIGATIONAL TREATMENT ADVERSE BENEFIT
8 DETERMINATIONS.

9 (A) REQUEST FOR REVIEW.--

10 (1) WITHIN FOUR MONTHS OF THE DATE OF RECEIPT OF A
11 NOTICE OF AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE
12 BENEFIT DETERMINATION UNDER SECTION 2164.2 THAT INVOLVES A
13 DENIAL OF COVERAGE BASED ON A DETERMINATION THAT THE HEALTH
14 CARE SERVICES RECOMMENDED OR REQUESTED ARE EXPERIMENTAL OR
15 INVESTIGATIONAL, A COVERED PERSON, OR THE COVERED PERSON'S
16 AUTHORIZED REPRESENTATIVE, MAY FILE A REQUEST FOR EXTERNAL
17 REVIEW WITH THE DEPARTMENT.

18 (2) A COVERED PERSON, OR THE COVERED PERSON'S AUTHORIZED
19 REPRESENTATIVE, MAY MAKE AN ORAL REQUEST FOR EXPEDITED
20 EXTERNAL REVIEW OF THE ADVERSE BENEFIT DETERMINATION OR FINAL
21 ADVERSE BENEFIT DETERMINATION UNDER PARAGRAPH (1) IF THE
22 COVERED PERSON'S TREATING HEALTH CARE PROVIDER CERTIFICATES
23 IN WRITING THAT THE RECOMMENDED OR REQUESTED HEALTH CARE
24 SERVICES THAT ARE THE SUBJECT OF THE REQUEST WOULD BE
25 SIGNIFICANTLY LESS EFFECTIVE IF NOT PROMPTLY INITIATED. UPON
26 RECEIPT OF A REQUEST FOR AN EXPEDITED EXTERNAL REVIEW, THE
27 DEPARTMENT SHALL NOTIFY THE INSURER WITHIN 24 HOURS.

28 (3) WITH RESPECT TO NOTICE OF AN INSURER'S ELIGIBILITY
29 DETERMINATION:

30 (I) UPON NOTICE OF THE REQUEST FOR EXPEDITED

1 EXTERNAL REVIEW, THE INSURER SHALL IMMEDIATELY DETERMINE
2 WHETHER THE REQUEST MEETS THE REQUIREMENTS FOR REVIEW
3 UNDER SUBSECTION (B). THE INSURER SHALL, WITHIN 24 HOURS,
4 NOTIFY THE DEPARTMENT, THE COVERED PERSON AND, IF
5 APPLICABLE, THE COVERED PERSON'S AUTHORIZED
6 REPRESENTATIVE, OF THE INSURER'S ELIGIBILITY
7 DETERMINATION.

8 (II) THE DEPARTMENT MAY SPECIFY THE FORM FOR THE
9 INSURER'S NOTICE OF INITIAL DETERMINATION UNDER
10 SUBPARAGRAPH (I) AND ANY SUPPORTING INFORMATION TO BE
11 INCLUDED IN THE NOTICE.

12 (III) THE NOTICE OF INITIAL DETERMINATION UNDER
13 SUBPARAGRAPH (I) SHALL INCLUDE A STATEMENT INFORMING THE
14 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S
15 AUTHORIZED REPRESENTATIVE, OF AN INSURER'S INITIAL
16 DETERMINATION THAT THE EXTERNAL REVIEW REQUEST IS
17 INELIGIBLE FOR REVIEW AND THAT THE EXTERNAL REVIEW
18 REQUEST MAY BE APPEALED TO THE DEPARTMENT.

19 (3) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION,
20 THE DEPARTMENT MAY DECIDE THAT A REQUEST IS ELIGIBLE FOR
21 EXTERNAL REVIEW UNDER PARAGRAPH (2) AND REQUIRE THAT THE
22 REQUEST BE REFERRED FOR EXTERNAL REVIEW. THE DEPARTMENT'S
23 DECISION SHALL BE MADE IN ACCORDANCE WITH THE TERMS OF THE
24 COVERED PERSON'S HEALTH INSURANCE POLICY AND SHALL BE SUBJECT
25 TO ALL APPLICABLE PROVISIONS OF THIS SUBDIVISION. THE
26 DEPARTMENT'S DECISION SHALL BE BINDING ON THE INSURER AND THE
27 COVERED PERSON AND MAY BE APPEALED TO THE COMMISSIONER.
28 CONSIDERATION OF AN APPEAL MAY NOT DELAY OR TERMINATE THE
29 EXTERNAL REVIEW.

30 (4) UPON RECEIPT OF A NOTICE UNDER PARAGRAPH (2), THE

1 DEPARTMENT SHALL, WITHIN 24 HOURS, ASSIGN AN IRO TO REVIEW
2 THE EXPEDITED REQUEST FROM THE LIST OF APPROVED IROS COMPILED
3 AND MAINTAINED BY THE DEPARTMENT UNDER SECTION 2164.9 AND
4 NOTIFY THE INSURER OF THE NAME OF THE ASSIGNED IRO. THE
5 INSURER, OR A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY
6 THE INSURER, SHALL THEN PROVIDE OR TRANSMIT ALL NECESSARY
7 DOCUMENTS AND INFORMATION CONSIDERED IN MAKING THE ADVERSE
8 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION
9 TO THE ASSIGNED IRO:

10 (I) ELECTRONICALLY.

11 (II) BY TELEPHONE.

12 (III) BY FACSIMILE.

13 (IV) BY ANY OTHER AVAILABLE EXPEDITIOUS METHOD.

14 (B) PRELIMINARY REVIEW REQUEST.--

15 (1) EXCEPT FOR A REQUEST FOR AN EXPEDITED EXTERNAL
16 REVIEW MADE UNDER SUBSECTION (A) (2), WITHIN ONE BUSINESS DAY
17 OF THE DATE OF RECEIPT OF THE REQUEST FOR EXTERNAL REVIEW,
18 THE DEPARTMENT SHALL NOTIFY THE INSURER OF THE DEPARTMENT'S
19 RECEIPT OF THE REQUEST.

20 (2) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF
21 THE NOTICE SENT UNDER PARAGRAPH (1), THE INSURER SHALL
22 CONDUCT AND COMPLETE A PRELIMINARY REVIEW OF THE REQUEST TO
23 DETERMINE WHETHER:

24 (I) THE INDIVIDUAL IS OR WAS A COVERED PERSON UNDER
25 THE HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE
26 SERVICES WERE RECOMMENDED OR REQUESTED OR, IN THE CASE OF
27 A RETROSPECTIVE REVIEW, WAS A COVERED PERSON UNDER THE
28 HEALTH INSURANCE POLICY AT THE TIME THE HEALTH CARE
29 SERVICES WERE PROVIDED.

30 (II) THE RECOMMENDED OR REQUESTED HEALTH CARE

1 SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT
2 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION:

3 (A) IS A COVERED BENEFIT UNDER THE COVERED
4 PERSON'S HEALTH INSURANCE POLICY, EXCEPT FOR THE
5 INSURER'S DETERMINATION THAT THE HEALTH CARE SERVICE
6 IS EXPERIMENTAL OR INVESTIGATIONAL FOR A PARTICULAR
7 MEDICAL CONDITION.

8 (B) IS NOT EXPLICITLY LISTED AS AN EXCLUDED
9 BENEFIT UNDER THE COVERED PERSON'S HEALTH INSURANCE
10 POLICY.

11 (III) THE COVERED PERSON'S TREATING HEALTH CARE
12 PROVIDER HAS CERTIFIED THAT ONE OF THE FOLLOWING
13 SITUATIONS IS APPLICABLE:

14 (A) STANDARD HEALTH CARE SERVICES HAVE NOT BEEN
15 EFFECTIVE IN IMPROVING THE CONDITION OF THE COVERED
16 PERSON.

17 (B) STANDARD HEALTH CARE SERVICES ARE NOT
18 MEDICALLY APPROPRIATE FOR THE COVERED PERSON.

19 (C) THERE ARE NO AVAILABLE STANDARD HEALTH CARE
20 SERVICES COVERED UNDER THE HEALTH INSURANCE POLICY
21 THAT ARE MORE BENEFICIAL THAN THE RECOMMENDED OR
22 REQUESTED HEALTH CARE SERVICES DESCRIBED IN
23 SUBPARAGRAPH (IV).

24 (IV) THE COVERED PERSON'S TREATING HEALTH CARE
25 PROVIDER EITHER:

26 (A) HAS RECOMMENDED HEALTH CARE SERVICES THAT
27 THE HEALTH CARE PROVIDER CERTIFIES, IN WRITING, ARE
28 LIKELY TO BE MORE BENEFICIAL TO THE COVERED PERSON,
29 IN THE HEALTH CARE PROVIDER'S OPINION, THAN AVAILABLE
30 STANDARD HEALTH CARE SERVICES.

1 (B) HAS CERTIFIED IN WRITING THAT SCIENTIFICALLY
2 VALID STUDIES USING ACCEPTED PROTOCOLS DEMONSTRATE
3 THAT THE HEALTH CARE SERVICES REQUESTED BY THE
4 COVERED PERSON WHO IS THE SUBJECT OF THE ADVERSE
5 BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
6 DETERMINATION, ARE LIKELY TO BE MORE BENEFICIAL TO
7 THE COVERED PERSON THAN ANY AVAILABLE STANDARD HEALTH
8 CARE SERVICES, WHEN THE TREATING HEALTH CARE PROVIDER
9 IS A LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE
10 PHYSICIAN QUALIFIED TO PRACTICE IN THE AREA OF
11 MEDICINE APPROPRIATE TO TREAT THE COVERED PERSON'S
12 CONDITION.

13 (V) THE COVERED PERSON HAS EXHAUSTED THE INSURER'S
14 INTERNAL CLAIMS AND APPEAL PROCESS UNDER SECTION 2164,
15 UNLESS THE COVERED PERSON IS NOT REQUIRED TO EXHAUST THE
16 INSURER'S INTERNAL APPEAL PROCESS UNDER SECTION 2164.4.

17 (VI) THE COVERED PERSON HAS PROVIDED ALL THE
18 INFORMATION AND FORMS REQUIRED BY THE DEPARTMENT THAT ARE
19 NECESSARY TO PROCESS AN EXTERNAL REVIEW, INCLUDING THE
20 RELEASE FORM PROVIDED UNDER SECTION 2164.2(B).

21 (C) NOTICE OF INITIAL DETERMINATION.--

22 (1) WITHIN ONE BUSINESS DAY OF COMPLETION OF THE
23 PRELIMINARY REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT
24 AND COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S
25 AUTHORIZED REPRESENTATIVE, IN WRITING WHETHER THE REQUEST IS
26 COMPLETE AND ELIGIBLE FOR EXTERNAL REVIEW.

27 (2) IF THE REQUEST:

28 (I) IS NOT COMPLETE, THE INSURER SHALL INFORM THE
29 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S
30 AUTHORIZED REPRESENTATIVE AND THE DEPARTMENT IN WRITING

1 AND INCLUDE IN THE NOTICE WHAT INFORMATION OR MATERIALS
2 ARE NEEDED TO MAKE THE REQUEST COMPLETE.

3 (II) IS NOT ELIGIBLE FOR EXTERNAL REVIEW, THE
4 INSURER SHALL INFORM THE COVERED PERSON AND, IF
5 APPLICABLE, THE COVERED PERSON'S AUTHORIZED
6 REPRESENTATIVE AND THE DEPARTMENT IN WRITING AND INCLUDE
7 IN THE NOTICE THE REASONS FOR THE REQUEST'S
8 INELIGIBILITY.

9 (3) NOTIFICATION PROVIDED UNDER PARAGRAPH (2) SHALL BE
10 PROVIDED IN A FORM SPECIFIED BY THE DEPARTMENT AND INCLUDE A
11 STATEMENT INFORMING THE COVERED PERSON AND, IF APPLICABLE,
12 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE OF AN
13 INSURER'S INITIAL DETERMINATION THAT THE REQUEST IS
14 INELIGIBLE FOR EXTERNAL REVIEW AND THAT THE EXTERNAL REVIEW
15 REQUEST MAY BE APPEALED TO THE DEPARTMENT.

16 (4) NOTWITHSTANDING AN INSURER'S INITIAL DETERMINATION
17 THAT THE REQUEST IS INELIGIBLE FOR REVIEW, THE DEPARTMENT MAY
18 DETERMINE, BASED UPON THE TERMS OF THE COVERED PERSON'S
19 HEALTH INSURANCE POLICY, THAT THE REQUEST IS ELIGIBLE FOR
20 EXTERNAL REVIEW UNDER SECTION 2164.5. THE DETERMINATION SHALL
21 BE BINDING ON THE INSURER AND THE COVERED PERSON AND MAY BE
22 APPEALED TO THE COMMISSIONER. CONSIDERATION OF THE APPEAL MAY
23 NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

24 (5) WHEN A REQUEST IS DETERMINED TO BE ELIGIBLE FOR
25 EXTERNAL REVIEW, THE INSURER SHALL NOTIFY THE DEPARTMENT, THE
26 COVERED PERSON AND, IF APPLICABLE, THE COVERED PERSON'S
27 AUTHORIZED REPRESENTATIVE.

28 (D) PROCEDURE FOR REVIEW OF REQUESTS ELIGIBLE FOR EXTERNAL
29 REVIEW.--

30 (1) WITHIN ONE BUSINESS DAY OF THE DATE OF RECEIPT OF

1 NOTICE THAT A REQUEST IS ELIGIBLE FOR EXTERNAL REVIEW
2 FOLLOWING THE PRELIMINARY REVIEW CONDUCTED UNDER SUBSECTION
3 (C), THE DEPARTMENT SHALL:

4 (I) ASSIGN AN IRO TO CONDUCT THE EXTERNAL REVIEW
5 FROM THE LIST OF APPROVED IROS COMPILED AND MAINTAINED BY
6 THE DEPARTMENT UNDER SECTION 2164.9 AND NOTIFY THE
7 INSURER OF THE NAME OF THE ASSIGNED IRO.

8 (II) NOTIFY IN WRITING THE COVERED PERSON AND, IF
9 APPLICABLE, THE COVERED PERSON'S AUTHORIZED
10 REPRESENTATIVE OF THE REQUEST'S ELIGIBILITY AND
11 ACCEPTANCE FOR EXTERNAL REVIEW. THE NOTIFICATION SHALL
12 INCLUDE A STATEMENT THAT THE COVERED PERSON, OR THE
13 COVERED PERSON'S AUTHORIZED REPRESENTATIVE, MAY SUBMIT IN
14 WRITING TO THE ASSIGNED IRO, WITHIN FIVE BUSINESS DAYS OF
15 THE DATE OF RECEIPT OF THE NOTICE PROVIDED UNDER
16 SUBPARAGRAPH (I), ADDITIONAL INFORMATION THAT THE IRO
17 SHALL CONSIDER WHEN CONDUCTING THE EXTERNAL REVIEW. THE
18 IRO MAY ACCEPT AND CONSIDER ADDITIONAL INFORMATION
19 SUBMITTED AFTER FIVE BUSINESS DAYS.

20 (2) WITHIN ONE BUSINESS DAY OF THE RECEIPT OF THE NOTICE
21 OF ASSIGNMENT TO CONDUCT THE EXTERNAL REVIEW UNDER PARAGRAPH
22 (1), THE ASSIGNED IRO SHALL:

23 (I) SELECT ONE OR MORE CLINICAL REVIEWERS UNDER
24 PARAGRAPH (3) TO CONDUCT THE EXTERNAL REVIEW.

25 (II) BASED ON THE OPINION OR OPINIONS OF THE
26 CLINICAL REVIEWER OR REVIEWERS, MAKE A DECISION TO UPHOLD
27 OR REVERSE THE ADVERSE BENEFIT DETERMINATION OR FINAL
28 ADVERSE BENEFIT DETERMINATION.

29 (3) IN SELECTING A CLINICAL REVIEWER, THE ASSIGNED IRO
30 SHALL SELECT A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO

1 MEETS THE MINIMUM QUALIFICATIONS DESCRIBED IN SECTION 2611.1
2 AND, THROUGH CLINICAL EXPERIENCE IN THE PAST THREE YEARS, HAS
3 EXPERTISE IN THE TREATMENT OF THE COVERED PERSON'S CONDITION
4 AND IS KNOWLEDGEABLE ABOUT THE RECOMMENDED OR REQUESTED
5 HEALTH CARE SERVICE. THE COVERED PERSON, THE COVERED PERSON'S
6 AUTHORIZED REPRESENTATIVE AND, IF APPLICABLE, THE INSURER MAY
7 NOT CHOOSE OR CONTROL THE CHOICE OF THE PHYSICIAN OR OTHER
8 HEALTH CARE PROVIDER TO BE SELECTED TO CONDUCT THE EXTERNAL
9 REVIEW.

10 (4) IN ACCORDANCE WITH SUBSECTION (E), EACH CLINICAL
11 REVIEWER SHALL PROVIDE A WRITTEN OPINION TO THE ASSIGNED IRO
12 REGARDING WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE
13 SERVICE SHOULD BE COVERED.

14 (5) THE ASSIGNED CLINICAL REVIEWER IS NOT BOUND BY A
15 DECISION OR CONCLUSION REACHED DURING THE INSURER'S INTERNAL
16 CLAIMS AND APPEAL PROCESS UNDER SECTION 2164.

17 (E) FORWARDING OF REQUIRED DOCUMENTS.--

18 (1) WITHIN FIVE BUSINESS DAYS OF THE DATE OF RECEIPT OF
19 THE NOTICE PROVIDED UNDER SUBSECTION (D) (1), THE INSURER, OR
20 A UTILIZATION REVIEW ORGANIZATION DESIGNATED BY THE INSURER,
21 SHALL PROVIDE TO THE ASSIGNED IRO THE DOCUMENTS AND
22 INFORMATION CONSIDERED IN MAKING THE ADVERSE BENEFIT
23 DETERMINATION OR THE FINAL ADVERSE BENEFIT DETERMINATION.

24 (2) EXCEPT AS PROVIDED IN PARAGRAPH (3), FAILURE BY THE
25 INSURER, OR BY A UTILIZATION REVIEW ORGANIZATION DESIGNATED
26 BY THE INSURER, TO PROVIDE THE DOCUMENTS AND INFORMATION
27 WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH (1) MAY NOT
28 DELAY THE CONDUCT OF THE EXTERNAL REVIEW.

29 (3) IF THE INSURER, OR A UTILIZATION REVIEW ORGANIZATION
30 DESIGNATED BY THE INSURER, FAILS TO PROVIDE THE DOCUMENTS AND

1 INFORMATION WITHIN THE TIME PERIOD SPECIFIED IN PARAGRAPH
2 (1), THE ASSIGNED IRO MAY TERMINATE THE EXTERNAL REVIEW AND
3 MAKE A DECISION TO REVERSE THE ADVERSE BENEFIT DETERMINATION
4 OR FINAL ADVERSE BENEFIT DETERMINATION. WITHIN 24 HOURS UPON
5 MAKING THE DECISION, THE IRO SHALL NOTIFY THE DEPARTMENT, THE
6 INSURER, THE COVERED PERSON, AND, IF APPLICABLE, THE COVERED
7 PERSON'S AUTHORIZED REPRESENTATIVE.

8 (F) REVIEW OF INFORMATION.--

9 (1) EACH CLINICAL REVIEWER SELECTED UNDER SUBSECTION (D)
10 SHALL REVIEW ALL OF THE INFORMATION AND DOCUMENTS RECEIVED
11 UNDER SUBSECTION (E) AND OTHER INFORMATION SUBMITTED IN
12 WRITING BY THE COVERED PERSON OR COVERED PERSON'S AUTHORIZED
13 REPRESENTATIVE UNDER SUBSECTION (D) (1) (II).

14 (2) WITHIN ONE BUSINESS DAY OF RECEIPT OF INFORMATION
15 SUBMITTED BY THE COVERED PERSON OR COVERED PERSON'S
16 AUTHORIZED REPRESENTATIVE UNDER SUBSECTION (D) (1) (II), THE
17 ASSIGNED IRO SHALL FORWARD THE INFORMATION TO THE INSURER.

18 (G) RECONSIDERATION BY INSURER.--

19 (1) UPON RECEIPT OF THE INFORMATION, IF ANY, REQUIRED TO
20 BE FORWARDED UNDER SUBSECTION (F) (2), THE INSURER MAY
21 RECONSIDER AN ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE
22 BENEFIT DETERMINATION THAT IS THE SUBJECT OF THE EXTERNAL
23 REVIEW.

24 (2) RECONSIDERATION BY THE INSURER OF AN ADVERSE BENEFIT
25 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION UNDER
26 PARAGRAPH (1) MAY NOT DELAY OR TERMINATE THE EXTERNAL REVIEW.

27 (3) THE EXTERNAL REVIEW MAY BE TERMINATED WITHOUT AN IRO
28 DETERMINATION ONLY IF THE INSURER DECIDES, UPON COMPLETION OF
29 RECONSIDERATION, TO REVERSE THE ADVERSE BENEFIT DETERMINATION
30 OR FINAL ADVERSE BENEFIT DETERMINATION AND PROVIDE COVERAGE

1 OR PAYMENT FOR THE RECOMMENDED HEALTH CARE SERVICE THAT IS
2 THE SUBJECT OF THE EXTERNAL REVIEW.

3 (4) WITHIN ONE BUSINESS DAY OF MAKING THE DECISION TO
4 REVERSE THE INSURER'S ADVERSE BENEFIT DETERMINATION OR FINAL
5 ADVERSE BENEFIT DETERMINATION, AS PROVIDED IN PARAGRAPH (3),
6 THE INSURER SHALL NOTIFY THE DEPARTMENT, THE ASSIGNED IRO,
7 THE COVERED PERSON, AND, IF APPLICABLE, THE COVERED PERSON'S
8 AUTHORIZED REPRESENTATIVE, IN WRITING OF THE INSURER'S
9 DECISION.

10 (5) THE ASSIGNED IRO SHALL TERMINATE THE EXTERNAL REVIEW
11 UPON RECEIPT OF THE NOTICE FROM THE INSURER UNDER PARAGRAPH
12 (4).

13 (H) CLINICAL REVIEW PROCESS.--

14 (1) EXCEPT AS PROVIDED IN PARAGRAPH (3), WITHIN 20 DAYS
15 OF BEING SELECTED IN ACCORDANCE WITH SUBSECTION (D) TO
16 CONDUCT THE EXTERNAL REVIEW, EACH CLINICAL REVIEWER SHALL
17 PROVIDE AN OPINION TO THE ASSIGNED IRO REGARDING WHETHER THE
18 RECOMMENDED OR REQUESTED HEALTH CARE SERVICE SHOULD BE
19 COVERED.

20 (2) EXCEPT FOR AN OPINION PROVIDED UNDER PARAGRAPH (3),
21 A CLINICAL REVIEWER'S OPINION SHALL BE IN WRITING AND INCLUDE
22 THE FOLLOWING INFORMATION:

23 (I) A DESCRIPTION OF THE COVERED PERSON'S MEDICAL
24 CONDITION.

25 (II) A DESCRIPTION OF THE INDICATORS RELEVANT TO
26 DETERMINING WHETHER THERE IS SUFFICIENT EVIDENCE TO
27 DEMONSTRATE THAT:

28 (A) THE RECOMMENDED OR REQUESTED HEALTH CARE
29 SERVICE IS MORE LIKELY THAN NOT TO BE BENEFICIAL TO
30 THE COVERED PERSON THAN ANY AVAILABLE STANDARD HEALTH

1 CARE SERVICE.

2 (B) THE ADVERSE RISKS OF THE RECOMMENDED OR
3 REQUESTED HEALTH CARE SERVICE WOULD NOT BE
4 SUBSTANTIALLY INCREASED OVER THE ADVERSE RISKS OF
5 AVAILABLE STANDARD HEALTH CARE SERVICE.

6 (III) A DESCRIPTION AND ANALYSIS OF MEDICAL OR
7 SCIENTIFIC EVIDENCE CONSIDERED IN REACHING THE OPINION.

8 (IV) A DESCRIPTION AND ANALYSIS OF AN EVIDENCE-BASED
9 STANDARD.

10 (V) INFORMATION ON WHETHER THE REVIEWER'S RATIONALE
11 FOR THE OPINION IS BASED ON SUBSECTION (I) (5) (I) OR (II).

12 (3) THE FOLLOWING SHALL APPLY:

13 (I) FOR AN EXPEDITED EXTERNAL REVIEW, A CLINICAL
14 REVIEWER SHALL PROVIDE AN OPINION ORALLY OR IN WRITING TO
15 THE ASSIGNED IRO AS EXPEDITIOUSLY AS THE COVERED PERSON'S
16 MEDICAL CONDITION OR CIRCUMSTANCES REQUIRE, BUT IN NO
17 EVENT MORE THAN FIVE CALENDAR DAYS AFTER BEING SELECTED
18 IN ACCORDANCE WITH SUBSECTION (D).

19 (II) IF THE OPINION PROVIDED UNDER SUBPARAGRAPH (I)
20 IS NOT IN WRITING, WITHIN 48 HOURS OF THE DATE THE
21 OPINION WAS PROVIDED, THE CLINICAL REVIEWER SHALL PROVIDE
22 WRITTEN CONFIRMATION OF THE OPINION TO THE ASSIGNED IRO
23 AND INCLUDE THE INFORMATION REQUIRED UNDER PARAGRAPH (2).

24 (I) FACTORS TO BE CONSIDERED.--IN ADDITION TO THE DOCUMENTS
25 AND INFORMATION PROVIDED UNDER SUBSECTION (A) (2) OR (E), A
26 CLINICAL REVIEWER SELECTED UNDER SUBSECTION (D), TO THE EXTENT
27 THE INFORMATION OR DOCUMENTS ARE AVAILABLE AND THE REVIEWER
28 CONSIDERS APPROPRIATE, SHALL CONSIDER THE FOLLOWING IN REACHING
29 AN OPINION UNDER SUBSECTION (H):

30 (1) THE COVERED PERSON'S MEDICAL RECORDS.

1 (2) THE ATTENDING HEALTH CARE PROVIDER'S RECOMMENDATION.

2 (3) CONSULTING REPORTS FROM APPROPRIATE HEALTH CARE
3 PROVIDERS AND OTHER DOCUMENTS SUBMITTED BY THE INSURER, THE
4 COVERED PERSON, AND, IF APPLICABLE, THE COVERED PERSON'S
5 AUTHORIZED REPRESENTATIVE OR TREATING PROVIDER.

6 (4) THE TERMS OF COVERAGE UNDER THE COVERED PERSON'S
7 HEALTH INSURANCE POLICY TO ENSURE THAT THE IRO'S DECISION IS
8 NOT CONTRARY TO THE TERMS.

9 (5) WHETHER EITHER OF THE FOLLOWING IS SATISFIED:

10 (I) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
11 HAS BEEN APPROVED BY THE UNITED STATES FOOD AND DRUG
12 ADMINISTRATION, IF APPLICABLE, FOR THE CONDITION.

13 (II) MEDICAL OR SCIENTIFIC EVIDENCE OR EVIDENCE-
14 BASED STANDARDS DEMONSTRATE THAT:

15 (A) THE EXPECTED BENEFIT OF THE RECOMMENDED OR
16 REQUESTED HEALTH CARE SERVICE IS MORE LIKELY THAN NOT
17 TO BE BENEFICIAL TO THE COVERED PERSON THAN ANY
18 AVAILABLE STANDARD HEALTH CARE SERVICE.

19 (B) THE ADVERSE RISKS OF THE RECOMMENDED OR
20 REQUESTED HEALTH CARE SERVICE WOULD NOT BE
21 SUBSTANTIALLY INCREASED OVER THE ADVERSE RISKS OF AN
22 AVAILABLE STANDARD HEALTH CARE SERVICE.

23 (J) NOTICE OF DECISION.--

24 (1) WITHIN 20 DAYS OF THE DATE THE ASSIGNED IRO RECEIVES
25 THE OPINION OF A CLINICAL REVIEWER, THE ASSIGNED IRO SHALL
26 PROVIDE WRITTEN NOTICE OF THE ASSIGNED IRO'S DECISION TO
27 UPHOLD OR REVERSE THE ADVERSE BENEFIT DETERMINATION TO:

28 (I) THE COVERED PERSON.

29 (II) IF APPLICABLE, THE COVERED PERSON'S AUTHORIZED
30 REPRESENTATIVE.

1 (III) THE INSURER.

2 (IV) THE DEPARTMENT.

3 (2) IF A MAJORITY OF THE CLINICAL REVIEWERS RECOMMEND
4 THAT:

5 (I) THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
6 BE COVERED, THE IRO SHALL MAKE A DECISION TO REVERSE THE
7 INSURER'S ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE
8 BENEFIT DETERMINATION.

9 (II) THE RECOMMENDED OR REQUESTED HEALTH CARE
10 SERVICE NOT BE COVERED, THE IRO SHALL MAKE A DECISION TO
11 UPHOLD THE INSURER'S ADVERSE BENEFIT DETERMINATION OR
12 FINAL ADVERSE BENEFIT DETERMINATION.

13 (3) IF THE CLINICAL REVIEWERS ARE EVENLY DIVIDED AS TO
14 WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE
15 SHOULD BE COVERED:

16 (I) THE IRO SHALL OBTAIN THE OPINION OF AN
17 ADDITIONAL CLINICAL REVIEWER IN ORDER FOR THE IRO TO MAKE
18 A DECISION BASED ON THE OPINIONS OF A MAJORITY OF THE
19 CLINICAL REVIEWERS.

20 (II) THE ADDITIONAL CLINICAL REVIEWER SELECTED SHALL
21 USE THE SAME INFORMATION TO REACH AN OPINION AS THE
22 CLINICAL REVIEWERS WHO HAVE ALREADY SUBMITTED THEIR
23 OPINION.

24 (III) THE SELECTION OF THE ADDITIONAL CLINICAL
25 REVIEWER MAY NOT EXTEND THE TIME WITHIN WHICH THE
26 ASSIGNED IRO IS REQUIRED TO MAKE A DECISION.

27 (4) THE IRO SHALL INCLUDE THE FOLLOWING IN THE NOTICE
28 PROVIDED UNDER PARAGRAPH (1):

29 (I) A GENERAL DESCRIPTION OF THE REASON FOR THE
30 REQUEST FOR EXTERNAL REVIEW.

1 (II) THE WRITTEN OPINION OF EACH CLINICAL REVIEWER,
2 INCLUDING THE RECOMMENDATION OF EACH CLINICAL REVIEWER AS
3 TO WHETHER THE RECOMMENDED OR REQUESTED HEALTH CARE
4 SERVICE SHOULD BE COVERED AND THE RATIONALE FOR THE
5 REVIEWER'S RECOMMENDATION.

6 (III) THE DATE THE IRO WAS ASSIGNED BY THE
7 DEPARTMENT TO CONDUCT THE EXTERNAL REVIEW.

8 (IV) THE DATE OF THE EXTERNAL REVIEW.

9 (V) THE DATE OF THE IRO'S DECISION.

10 (VI) THE PRINCIPAL REASON OR REASONS FOR THE IRO'S
11 DECISION.

12 (VII) THE RATIONALE FOR THE IRO'S DECISION.

13 (5) UPON RECEIPT OF A NOTICE OF A DECISION UNDER
14 PARAGRAPH (1) REVERSING THE ADVERSE BENEFIT DETERMINATION OR
15 FINAL ADVERSE BENEFIT DETERMINATION, THE INSURER SHALL,
16 WITHIN 24 HOURS, APPROVE THE COVERAGE THAT WAS THE SUBJECT OF
17 THE ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
18 DETERMINATION.

19 (K) ASSIGNMENT OF IRO.--THE DEPARTMENT SHALL ASSIGN, ON A
20 RANDOM BASIS, AN APPROVED IRO AMONG THOSE QUALIFIED TO CONDUCT
21 THE PARTICULAR EXTERNAL REVIEW BASED ON THE NATURE OF THE HEALTH
22 CARE SERVICE THAT IS THE SUBJECT OF THE ADVERSE BENEFIT
23 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION, AND SHALL
24 CONSIDER THE CONFLICT-OF-INTEREST CONCERNS UNDER SECTION
25 2164.10(D).

26 SECTION 2164.8. BINDING NATURE OF EXTERNAL REVIEW DECISION.

27 (A) BINDING ON INSURER.--AN EXTERNAL REVIEW DECISION SHALL
28 BE BINDING ON THE INSURER, EXCEPT TO THE EXTENT THE INSURER HAS
29 OTHER REMEDIES AVAILABLE UNDER APPLICABLE STATE LAW.

30 (B) BINDING ON COVERED PERSON.--AN EXTERNAL REVIEW DECISION

1 SHALL BE BINDING ON A COVERED PERSON, EXCEPT TO THE EXTENT THE
2 COVERED PERSON HAS OTHER REMEDIES AVAILABLE UNDER APPLICABLE
3 FEDERAL AND STATE LAW.

4 (C) FINALITY OF DECISION.--NEITHER THE COVERED PERSON NOR
5 THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE MAY FILE A
6 SUBSEQUENT REQUEST FOR EXTERNAL REVIEW INVOLVING THE SAME
7 ADVERSE BENEFIT DETERMINATION OR FINAL ADVERSE BENEFIT
8 DETERMINATION FOR WHICH THE COVERED PERSON HAS ALREADY RECEIVED
9 AN EXTERNAL REVIEW DECISION UNDER THIS SUBARTICLE.

10 SECTION 2164.9. DEPARTMENT APPROVAL OF INDEPENDENT REVIEW
11 ORGANIZATIONS.

12 (A) GENERAL RULE.--THE DEPARTMENT MAY APPROVE AN IRO
13 ELIGIBLE TO BE ASSIGNED TO CONDUCT EXTERNAL REVIEWS UNDER THIS
14 SUBDIVISION.

15 (B) ELIGIBILITY REQUIREMENTS.--TO BE ELIGIBLE FOR APPROVAL
16 BY THE DEPARTMENT UNDER THIS SECTION TO CONDUCT EXTERNAL REVIEWS
17 UNDER THIS SUBDIVISION, AN IRO MUST:

18 (1) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, BE
19 ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING
20 ENTITY THAT THE DEPARTMENT HAS DETERMINED TO POSSESS IRO
21 ACCREDITATION STANDARDS THAT ARE EQUIVALENT TO OR EXCEED THE
22 MINIMUM QUALIFICATIONS FOR THE IROS ESTABLISHED UNDER SECTION
23 2611.1.

24 (2) SUBMIT AN APPLICATION FOR APPROVAL IN ACCORDANCE
25 WITH SUBSECTION (D).

26 (3) IDENTIFY THE IRO'S PROPOSED FEES FOR EXTERNAL
27 REVIEWS.

28 (C) FORM OF APPLICATION.--THE DEPARTMENT SHALL DEVELOP AN
29 APPLICATION FORM FOR INITIALLY APPROVING AND FOR RENEWING THE
30 APPROVAL OF IROS TO CONDUCT EXTERNAL REVIEWS.

1 (D) CONSIDERATION OF APPLICATION.--

2 (1) AN IRO SEEKING APPROVAL TO CONDUCT EXTERNAL REVIEWS
3 UNDER THIS SUBDIVISION SHALL SUBMIT THE APPLICATION FORM AND
4 INCLUDE WITH THE FORM ALL DOCUMENTATION AND INFORMATION
5 NECESSARY FOR THE DEPARTMENT TO DETERMINE WHETHER THE IRO
6 SATISFIES THE MINIMUM QUALIFICATIONS ESTABLISHED UNDER
7 SECTION 2164.10.

8 (2) THE DEPARTMENT MAY APPROVE AN IRO THAT IS NOT
9 ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING
10 ENTITY IF THERE ARE NO ACCEPTABLE NATIONALLY RECOGNIZED
11 PRIVATE ACCREDITING ENTITIES PROVIDING IRO ACCREDITATION.

12 (3) THE DEPARTMENT MAY CHARGE THE IRO AN APPLICATION FEE
13 TO BE SUBMITTED WITH AN APPLICATION FOR APPROVAL OR FOR
14 RENEWAL.

15 (4) THE DEPARTMENT MAY DECLINE TO CERTIFY AN IRO IF THE
16 IRO'S PROPOSED FEES FOR EXTERNAL REVIEWS ARE DETERMINED BY
17 THE DEPARTMENT TO BE UNREASONABLE.

18 (E) DURATION OF APPROVAL.--

19 (1) AN APPROVAL SHALL BE VALID FOR TWO YEARS UNLESS THE
20 DEPARTMENT DETERMINES BEFORE THE APPROVAL EXPIRES THAT THE
21 IRO NO LONGER SATISFIES THE MINIMUM QUALIFICATIONS
22 ESTABLISHED UNDER SECTION 2164.10.

23 (2) IF THE DEPARTMENT DETERMINES THAT AN IRO IS NO
24 LONGER ACCREDITED OR NO LONGER SATISFIES THE MINIMUM
25 REQUIREMENTS ESTABLISHED UNDER SECTION 2164.10, THE
26 DEPARTMENT MAY TERMINATE THE APPROVAL OF THE IRO AND REMOVE
27 THE IRO FROM THE LIST OF IROS APPROVED TO CONDUCT EXTERNAL
28 REVIEWS UNDER THIS SUBDIVISION.

29 (F) LIST OF APPROVED IROS.--THE DEPARTMENT SHALL MAINTAIN
30 AND PERIODICALLY UPDATE A LIST OF APPROVED IROS. THE DEPARTMENT

1 SHALL PERIODICALLY TRANSMIT NOTICE A LIST OF APPROVED IROS TO
2 THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION IN THE
3 PENNSYLVANIA BULLETIN.

4 (G) NO PROHIBITION.--NOTHING IN THIS SECTION OR IN SECTION
5 2164.10 SHALL PROHIBIT AN ENTITY CERTIFIED AS A UTILIZATION
6 REVIEW ENTITY FROM BEING APPROVED AS AN IRO.
7 SECTION 2164.10. MINIMUM QUALIFICATIONS FOR INDEPENDENT REVIEW
8 ORGANIZATIONS.

9 (A) REQUIREMENTS FOR DEPARTMENT APPROVAL.--TO BE APPROVED
10 UNDER SECTION 2164.9 TO CONDUCT EXTERNAL REVIEWS AND EXTERNAL
11 GRIEVANCES, AN IRO MUST ESTABLISH AND MAINTAIN WRITTEN POLICIES
12 AND PROCEDURES THAT GOVERN ALL ASPECTS OF BOTH THE STANDARD AND
13 EXPEDITED ADVERSE BENEFIT DETERMINATION EXTERNAL REVIEW AND
14 EXTERNAL GRIEVANCE REVIEW REQUIRED BY SECTIONS 2162, 2162.6 AND
15 2162.7 THAT INCLUDE, AT A MINIMUM:

16 (1) A QUALITY ASSURANCE MECHANISM IN PLACE THAT ENSURES:

17 (I) THAT AN EXTERNAL REVIEW IS CONDUCTED WITHIN THE
18 SPECIFIED TIME PERIOD AND THAT REQUIRED NOTICES ARE
19 PROVIDED IN A TIMELY MANNER.

20 (II) THE SELECTION OF QUALIFIED AND IMPARTIAL
21 CLINICAL REVIEWERS TO CONDUCT EXTERNAL REVIEW ON BEHALF
22 OF THE IRO, AND SUITABLE MATCHING OF REVIEWERS TO
23 SPECIFIC CASES.

24 (III) THAT AN IRO EMPLOYS OR CONTRACTS WITH AN
25 ADEQUATE NUMBER OF CLINICAL REVIEWERS TO SUITABLY MATCH
26 REVIEWERS TO SPECIFIC CASES.

27 (IV) THE CONFIDENTIALITY OF MEDICAL AND TREATMENT
28 RECORDS AND CLINICAL REVIEW CRITERIA.

29 (V) THAT A PERSON EMPLOYED BY OR UNDER CONTRACT WITH
30 THE IRO ADHERES TO THE REQUIREMENTS OF THIS SUBDIVISION.

1 (VI) THAT THE IRO AND ITS ASSIGNED CLINICAL
2 REVIEWERS ARE UNBIASED IN THE CONDUCT OF AN EXTERNAL
3 REVIEW.

4 (2) A TOLL-FREE TELEPHONE SERVICE TO RECEIVE INFORMATION
5 24 HOURS PER DAY, 7 DAYS PER WEEK, RELATED TO EXTERNAL
6 REVIEWS, THAT IS CAPABLE OF ACCEPTING, RECORDING OR PROVIDING
7 APPROPRIATE INSTRUCTION TO INCOMING TELEPHONE CALLERS DURING
8 OTHER-THAN-NORMAL BUSINESS HOURS.

9 (3) AN AGREEMENT TO MAINTAIN AND PROVIDE TO THE
10 DEPARTMENT THE INFORMATION DESCRIBED IN SECTION 2164.12.

11 (B) QUALIFICATIONS OF CLINICAL REVIEWER.--A CLINICAL
12 REVIEWER ASSIGNED BY AN IRO TO CONDUCT EXTERNAL REVIEW MUST BE A
13 PHYSICIAN OR OTHER APPROPRIATE HEALTH CARE PROVIDER WHO MEETS
14 THE FOLLOWING MINIMUM QUALIFICATIONS:

15 (1) HAS EXPERTISE IN THE TREATMENT OF THE COVERED
16 PERSON'S OR ENROLLEE'S MEDICAL CONDITION THAT IS THE SUBJECT
17 OF THE EXTERNAL REVIEW.

18 (2) IS KNOWLEDGEABLE ABOUT THE RECOMMENDED HEALTH CARE
19 SERVICE THROUGH RECENT OR CURRENT ACTUAL CLINICAL EXPERIENCE
20 TREATING PATIENTS WITH THE SAME OR SIMILAR MEDICAL CONDITION
21 OF THE COVERED PERSON OR ENROLLEE.

22 (3) HOLDS A NONRESTRICTED LICENSE IN A STATE OR
23 COMMONWEALTH OF THE UNITED STATES AND, FOR A PHYSICIAN, A
24 CURRENT CERTIFICATION FROM A RECOGNIZED AMERICAN MEDICAL
25 SPECIALTY BOARD IN THE AREA OR AREAS OF MEDICINE APPROPRIATE
26 TO THE SUBJECT OF THE EXTERNAL REVIEW.

27 (4) HAS NO HISTORY OF DISCIPLINARY ACTIONS OR SANCTIONS,
28 INCLUDING LOSS OF STAFF PRIVILEGES OR PARTICIPATION
29 RESTRICTIONS, THAT HAVE BEEN TAKEN OR ARE PENDING BY A
30 HOSPITAL, GOVERNMENTAL AGENCY OR UNIT OR REGULATORY BODY THAT

1 RAISE A SUBSTANTIAL QUESTION AS TO THE CLINICAL REVIEWER'S
2 PHYSICAL, MENTAL OR PROFESSIONAL COMPETENCE OR MORAL
3 CHARACTER.

4 (C) PROHIBITED RELATIONSHIPS.--IN ADDITION TO THE
5 REQUIREMENTS UNDER SUBSECTION (A), AN IRO MAY NOT OWN OR
6 CONTROL, BE A SUBSIDIARY OF OR IN ANY WAY BE OWNED OR CONTROLLED
7 BY OR EXERCISE CONTROL WITH AN INSURER OR MA OR CHIP MANAGED
8 CARE PLAN, A NATIONAL, STATE OR LOCAL TRADE ASSOCIATION OF
9 INSURERS OR MA OR CHIP MANAGED CARE PLANS, OR HEALTH CARE
10 PROVIDERS.

11 (D) CONFLICTS OF INTEREST.--

12 (1) IN ADDITION TO THE REQUIREMENTS UNDER THIS SECTION,
13 TO BE APPROVED UNDER SECTIONS 2162, 2162.6 OR 2162.7 TO
14 CONDUCT AN EXTERNAL REVIEW OF A SPECIFIED CASE, NEITHER THE
15 IRO SELECTED TO CONDUCT THE EXTERNAL REVIEW NOR A CLINICAL
16 REVIEWER ASSIGNED BY THE IRO TO CONDUCT THE EXTERNAL REVIEW
17 MAY HAVE A MATERIAL PROFESSIONAL, FAMILIAL OR FINANCIAL
18 CONFLICT OF INTEREST WITH ANY OF THE FOLLOWING:

19 (I) THE INSURER OR MA OR CHIP MANAGED CARE PLAN THAT
20 IS THE SUBJECT OF THE EXTERNAL REVIEW.

21 (II) THE COVERED PERSON OR ENROLLEE WHOSE TREATMENT
22 IS THE SUBJECT OF THE EXTERNAL REVIEW OR THE COVERED
23 PERSON'S OR ENROLLEE'S AUTHORIZED REPRESENTATIVE.

24 (III) AN OFFICER, DIRECTOR OR MANAGEMENT EMPLOYEE OF
25 THE INSURER OR MA OR CHIP MANAGED CARE PLAN THAT IS THE
26 SUBJECT OF THE EXTERNAL REVIEW.

27 (IV) THE HEALTH CARE PROVIDER, THE HEALTH CARE
28 PROVIDER'S MEDICAL GROUP OR INDEPENDENT PRACTICE
29 ASSOCIATION RECOMMENDING THE HEALTH CARE SERVICE THAT IS
30 THE SUBJECT OF THE EXTERNAL REVIEW.

1 (V) THE FACILITY AT WHICH THE RECOMMENDED HEALTH
2 CARE SERVICE WOULD BE PROVIDED.

3 (VI) THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL
4 DRUG, DEVICE, PROCEDURE OR OTHER THERAPY BEING
5 RECOMMENDED FOR THE COVERED PERSON OR ENROLLEE WHOSE
6 TREATMENT IS THE SUBJECT OF THE EXTERNAL REVIEW.

7 (2) IN DETERMINING WHETHER AN IRO OR CLINICAL REVIEWER
8 OF THE IRO HAS A MATERIAL PROFESSIONAL, FAMILIAL OR FINANCIAL
9 CONFLICT OF INTEREST FOR PURPOSES OF PARAGRAPH (1), THE
10 DEPARTMENT SHALL TAKE INTO CONSIDERATION SITUATIONS WHERE AN
11 APPARENT CONFLICT OF INTEREST UNDER PARAGRAPH (1) IS NOT
12 MATERIAL.

13 (E) ACCREDITATION.--

14 (1) AN IRO THAT IS ACCREDITED BY A NATIONALLY RECOGNIZED
15 PRIVATE ACCREDITING ENTITY THAT POSSESSES INDEPENDENT REVIEW
16 ACCREDITATION STANDARDS THAT THE DEPARTMENT HAS DETERMINED
17 ARE EQUIVALENT TO OR EXCEED THE MINIMUM QUALIFICATIONS OF
18 THIS SECTION SHALL BE PRESUMED TO BE IN COMPLIANCE WITH THIS
19 SECTION TO BE ELIGIBLE FOR APPROVAL UNDER SECTION 2164.9.

20 (2) THE DEPARTMENT SHALL INITIALLY AND PERIODICALLY
21 REVIEW THE IRO ACCREDITATION STANDARDS OF A NATIONALLY
22 RECOGNIZED PRIVATE ACCREDITING ENTITY TO DETERMINE WHETHER
23 THE ENTITY'S STANDARDS ARE, AND CONTINUE TO BE, EQUIVALENT TO
24 OR EXCEEDING THE MINIMUM QUALIFICATIONS ESTABLISHED UNDER
25 THIS SECTION. THE DEPARTMENT MAY ACCEPT A REVIEW CONDUCTED BY
26 THE NAIC FOR THE PURPOSES OF THE DETERMINATION UNDER THIS
27 PARAGRAPH.

28 (3) UPON REQUEST, A NATIONALLY RECOGNIZED PRIVATE
29 ACCREDITING ENTITY SHALL MAKE ITS CURRENT IRO ACCREDITATION
30 STANDARDS AVAILABLE TO THE DEPARTMENT OR THE NAIC IN ORDER

1 FOR THE DEPARTMENT TO DETERMINE IF THE ENTITY'S STANDARDS
2 EXCEED OR ARE EQUIVALENT TO THE MINIMUM QUALIFICATIONS
3 ESTABLISHED UNDER THIS SECTION. THE DEPARTMENT MAY EXCLUDE A
4 PRIVATE ACCREDITING ENTITY THAT IS NOT REVIEWED BY THE NAIC.
5 SECTION 2164.11. HOLD HARMLESS FOR INDEPENDENT REVIEW
6 ORGANIZATIONS.

7 NO IRO, CLINICAL REVIEWER WORKING ON BEHALF OF AN IRO OR AN
8 EMPLOYEE, AGENT OR CONTRACTOR OF AN IRO MAY BE HELD LIABLE FOR
9 DAMAGES TO A PERSON FOR AN OPINION RENDERED, OR ACT OR OMISSION
10 PERFORMED, WITHIN THE SCOPE OF THE ORGANIZATION'S OR PERSON'S
11 DUTIES UNDER THE LAW DURING OR UPON COMPLETION OF AN EXTERNAL
12 REVIEW CONDUCTED UNDER THIS SUBDIVISION, UNLESS THE OPINION WAS
13 RENDERED, OR ACT OR OMISSION PERFORMED, IN BAD FAITH OR INVOLVED
14 GROSS NEGLIGENCE.

15 SECTION 2164.12. EXTERNAL REVIEW REPORTING REQUIREMENTS.

16 (A) RECORDKEEPING BY IROS.--

17 (1) AN IRO ASSIGNED UNDER THIS SUBDIVISION TO CONDUCT AN
18 EXTERNAL REVIEW SHALL MAINTAIN WRITTEN RECORDS IN THE
19 AGGREGATE FOR THE ENTIRE COMMONWEALTH AND FOR EACH INSURER OR
20 MA OR CHIP MANAGED CARE PLAN, ON ALL REQUESTS FOR WHICH THE
21 IRO CONDUCTED AN EXTERNAL REVIEW DURING A CALENDAR YEAR.

22 (2) AN IRO REQUIRED TO MAINTAIN WRITTEN RECORDS UNDER
23 PARAGRAPH (1) ON ALL REQUESTS FOR EXTERNAL REVIEW FOR WHICH
24 THE IRO WAS ASSIGNED TO CONDUCT AN EXTERNAL REVIEW SHALL
25 SUBMIT TO THE DEPARTMENT, UPON REQUEST, A REPORT IN THE
26 FORMAT SPECIFIED BY THE DEPARTMENT.

27 (3) THE REPORT SHALL INCLUDE IN THE AGGREGATE, FOR THE
28 ENTIRE COMMONWEALTH AND FOR EACH INSURER OR MA OR CHIP
29 MANAGED CARE PLAN:

30 (I) THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL

1 REVIEW.

2 (II) THE NUMBER OF REQUESTS FOR EXTERNAL REVIEW
3 RESOLVE AND, OF THOSE RESOLVED, THE NUMBER RESOLVED
4 UPHOLDING THE ADVERSE BENEFIT DETERMINATION OR FINAL
5 ADVERSE BENEFIT DETERMINATION AND THE NUMBER RESOLVED
6 REVERSING THE ADVERSE BENEFIT DETERMINATION OR FINAL
7 ADVERSE BENEFIT DETERMINATION.

8 (III) THE AVERAGE LENGTH OF TIME FOR EXTERNAL REVIEW
9 REQUEST RESOLUTION.

10 (IV) A SUMMARY OF THE TYPES OF COVERAGES OR CASES
11 FOR WHICH AN EXTERNAL REVIEW WAS SOUGHT, PROVIDED IN A
12 FORMAT SPECIFIED BY THE DEPARTMENT.

13 (V) THE NUMBER OF EXTERNAL REVIEWS UNDER SECTIONS
14 2164.5 AND 2164.7 THAT WERE TERMINATED AS THE RESULT OF A
15 RECONSIDERATION BY THE INSURER OF THE ADVERSE BENEFIT
16 DETERMINATION OR FINAL ADVERSE BENEFIT DETERMINATION
17 AFTER THE RECEIPT OF ADDITIONAL INFORMATION FROM THE
18 COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED
19 REPRESENTATIVE.

20 (VI) OTHER INFORMATION THE DEPARTMENT MAY REQUEST OR
21 REQUIRE.

22 (4) THE IRO SHALL RETAIN THE WRITTEN RECORDS REQUIRED
23 UNDER THIS SUBSECTION FOR AT LEAST THREE YEARS.

24 (B) RECORDKEEPING BY INSURERS.--

25 (1) AN INSURER SHALL MAINTAIN WRITTEN RECORDS IN THE
26 AGGREGATE, FOR THE ENTIRE COMMONWEALTH, FOR EACH TYPE OF
27 HEALTH INSURANCE POLICY OFFERED BY THE INSURER, ON ALL
28 REQUESTS FOR EXTERNAL REVIEW AS TO WHICH THE INSURER RECEIVES
29 NOTICE FROM THE DEPARTMENT UNDER THIS SUBARTICLE.

30 (2) AN INSURER REQUIRED TO MAINTAIN WRITTEN RECORDS

1 UNDER PARAGRAPH (1) SHALL SUBMIT TO THE DEPARTMENT, UPON
2 REQUEST, A REPORT IN THE FORMAT SPECIFIED BY THE DEPARTMENT.

3 (3) THE REPORT SHALL INCLUDE IN THE AGGREGATE, FOR THE
4 ENTIRE COMMONWEALTH AND FOR EACH TYPE OF HEALTH INSURANCE
5 POLICY OFFERED BY THE INSURER:

6 (I) THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL
7 REVIEW.

8 (II) OF THE TOTAL NUMBER OF REQUESTS FOR EXTERNAL
9 REVIEW REPORTED UNDER SUBPARAGRAPH (I), THE NUMBER OF
10 REQUESTS DETERMINED ELIGIBLE FOR EXTERNAL REVIEW.

11 (III) OTHER INFORMATION THE DEPARTMENT MAY REQUEST
12 OR REQUIRE.

13 (4) THE INSURER SHALL RETAIN THE WRITTEN RECORDS
14 REQUIRED UNDER THIS SUBSECTION FOR AT LEAST THREE YEARS.

15 SECTION 2164.13. FUNDING OF EXTERNAL REVIEW.

16 (A) COST.--THE INSURER AGAINST WHICH A REQUEST FOR STANDARD
17 EXTERNAL REVIEW OR EXPEDITED EXTERNAL REVIEW UNDER SECTION
18 2164.5, 2164.6 OR 2164.7 IS FILED SHALL PAY THE COST OF THE IRO
19 TO CONDUCT THE EXTERNAL REVIEW.

20 (B) FEES.--THE FEES CHARGED BY AN IRO SHALL BE REASONABLE
21 AND CUSTOMARY. THE DEPARTMENT SHALL ANNUALLY TRANSMIT NOTICE OF
22 THE FEES FOR THE TYPES OF ADVERSE BENEFIT DETERMINATIONS UNDER
23 REVIEW TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION IN
24 THE PENNSYLVANIA BULLETIN.

25 (C) NO FEE.--A COVERED PERSON OR THE COVERED PERSON'S
26 AUTHORIZED REPRESENTATIVE MAY NOT BE CHARGED A FEE IN ORDER TO
27 FILE A REQUEST FOR EXTERNAL REVIEW.

28 SECTION 2164.14. AVAILABILITY OF FORMS.

29 (A) GENERAL RULE.--THE DEPARTMENT SHALL MAKE AVAILABLE, IN
30 AN ELECTRONIC FORMAT AND, UPON REQUEST, IN PRINT FORMAT, ANY

1 APPLICABLE FORMS ADOPTED BY THE DEPARTMENT RELATED TO AN ADVERSE
2 BENEFIT DETERMINATION REQUEST, NOTICE OF INITIAL DETERMINATION
3 BY INSURER, HEALTH CARE PROVIDER CERTIFICATION FOR EXPEDITED
4 REVIEW, INSURER ANNUAL REPORT, IRO INTERNAL REPORT AND OTHER
5 FORMS SPECIFIED BY THIS SUBDIVISION.

6 (B) LOCATION OF FORMS.--FORMS DESCRIBED IN SUBSECTION (A)
7 SHALL BE POSTED ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE INTERNET
8 WEBSITE.

9 (C) AMENDMENT AND REVISION.--IF FORMS DESCRIBED IN
10 SUBSECTION (A) ARE AMENDED OR REVISED, THE DEPARTMENT SHALL
11 TRANSMIT NOTICE OF THE CHANGES TO THE LEGISLATIVE REFERENCE
12 BUREAU FOR PUBLICATION IN THE PENNSYLVANIA BULLETIN.

13 SECTION 8. SECTION 2166, SUBDIVISION (K) HEADING OF ARTICLE
14 XXI AND SECTIONS 2171, 2181 AND 2182 OF THE ACT ARE AMENDED TO
15 READ:

16 SECTION 2166. PROMPT PAYMENT OF CLAIMS.--(A) [A LICENSED]
17 AN INSURER OR [A] MA OR CHIP MANAGED CARE PLAN SHALL PAY A CLEAN
18 CLAIM SUBMITTED BY A HEALTH CARE PROVIDER OR COVERED PERSON
19 WITHIN FORTY-FIVE (45) DAYS OF RECEIPT OF THE CLEAN CLAIM.

20 (B) IF [A LICENSED] AN INSURER OR [A] MA OR CHIP MANAGED
21 CARE PLAN FAILS TO REMIT THE PAYMENT AS PROVIDED UNDER
22 SUBSECTION (A), INTEREST AT TEN PER CENTUM (10%) PER ANNUM SHALL
23 BE ADDED TO THE AMOUNT OWED ON THE CLEAN CLAIM. INTEREST SHALL
24 BE CALCULATED BEGINNING THE DAY AFTER THE REQUIRED PAYMENT DATE
25 AND ENDING ON THE DATE THE CLAIM IS PAID. THE [LICENSED] INSURER
26 OR MA OR CHIP MANAGED CARE PLAN SHALL NOT BE REQUIRED TO PAY ANY
27 INTEREST CALCULATED TO BE LESS THAN TWO (\$2) DOLLARS.

28 (K) [HEALTH CARE PROVIDER AND MANAGED CARE PLAN
29 PROTECTION] CONSCIENCE PROTECTION.

30 SECTION 2171. [HEALTH CARE PROVIDER AND MANAGED CARE PLAN]

1 CONSCIENCE PROTECTION.-- (A) [A] AN INSURER OR MA OR CHIP
2 MANAGED CARE PLAN SHALL NOT EXCLUDE, DISCRIMINATE AGAINST OR
3 PENALIZE ANY HEALTH CARE PROVIDER FOR ITS REFUSAL TO ALLOW,
4 PERFORM, PARTICIPATE IN OR REFER FOR HEALTH CARE SERVICES WHEN
5 THE REFUSAL OF THE HEALTH CARE PROVIDER IS BASED ON MORAL OR
6 RELIGIOUS GROUNDS AND THAT PROVIDER MAKES ADEQUATE INFORMATION
7 AVAILABLE TO [ENROLLEES] COVERED PERSONS ENROLLEES OR, IF
8 APPLICABLE, PROSPECTIVE [ENROLLEES] COVERED PERSONS.

9 (B) NO PUBLIC INSTITUTION, PUBLIC OFFICIAL OR PUBLIC AGENCY
10 MAY TAKE DISCIPLINARY ACTION AGAINST, DENY LICENSURE OR
11 CERTIFICATION OR PENALIZE ANY PERSON, ASSOCIATION OR CORPORATION
12 ATTEMPTING TO ESTABLISH A [PLAN] HEALTH ARE COVERAGE ARRANGEMENT
13 OR OPERATING, EXPANDING OR IMPROVING AN EXISTING INSURER OR MA
14 OR CHIP MANAGED CARE PLAN BECAUSE THE PERSON, ASSOCIATION OR
15 CORPORATION REFUSES TO PROVIDE ANY PARTICULAR FORM OF HEALTH
16 CARE SERVICES OR OTHER SERVICES OR SUPPLIES COVERED BY OTHER
17 INSURERS OR MA OR CHIP MANAGED CARE PLANS WHEN THE REFUSAL IS
18 BASED ON MORAL OR RELIGIOUS GROUNDS.

19 SECTION 2181. DEPARTMENTAL POWERS AND DUTIES.-- (A) [THE
20 DEPARTMENT SHALL REQUIRE THAT RECORDS] RECORDS AND DOCUMENTS
21 SUBMITTED TO [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN OR
22 UTILIZATION REVIEW ENTITY AS PART OF ANY COMPLAINT [OR],
23 GRIEVANCE, INTERNAL APPEALS OR ADVERSE BENEFIT DETERMINATION
24 SHALL BE MADE AVAILABLE TO THE DEPARTMENT, UPON REQUEST, FOR
25 PURPOSES OF ENFORCEMENT OR COMPLIANCE WITH THIS ARTICLE.

26 (B) THE DEPARTMENT SHALL COMPILE DATA RECEIVED FROM [A] AN
27 INSURER OR MA OR CHIP MANAGED CARE PLAN ON AN ANNUAL BASIS
28 REGARDING THE NUMBER, TYPE AND DISPOSITION OF COMPLAINTS [AND],
29 GRIEVANCES, INTERNAL APPEALS AND ADVERSE BENEFITS DETERMINATIONS
30 FILED WITH [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN UNDER

1 THIS ARTICLE.

2 (C) THE DEPARTMENT SHALL ISSUE GUIDELINES IDENTIFYING THOSE
3 PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN
4 THE "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE
5 ORGANIZATIONS" PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY
6 ASSURANCE. THESE GUIDELINES SHALL BE PUBLISHED IN THE
7 PENNSYLVANIA BULLETIN AND UPDATED AS NECESSARY. COPIES OF THE
8 GUIDELINES SHALL BE MADE AVAILABLE TO INSURERS, MA OR CHIP
9 MANAGED CARE PLANS, HEALTH CARE PROVIDERS AND COVERED PERSONS
10 AND ENROLLEES UPON REQUEST.

11 (D) THE DEPARTMENT [AND THE INSURANCE DEPARTMENT] SHALL
12 ENSURE COMPLIANCE WITH THIS ARTICLE. THE [APPROPRIATE]
13 DEPARTMENT [SHALL] MAY INVESTIGATE POTENTIAL VIOLATIONS OF THE
14 ARTICLE BASED UPON INFORMATION RECEIVED FROM COVERED PERSONS,
15 ENROLLEES, HEALTH CARE PROVIDERS AND OTHER SOURCES [IN ORDER TO
16 ENSURE COMPLIANCE WITH THIS ARTICLE].

17 [(E) THE DEPARTMENT AND THE INSURANCE DEPARTMENT SHALL
18 PROMULGATE SUCH REGULATIONS AS MAY BE NECESSARY TO CARRY OUT THE
19 PROVISIONS OF THIS ARTICLE.]

20 (F) THE DEPARTMENT [IN COOPERATION WITH THE INSURANCE
21 DEPARTMENT] SHALL SUBMIT AN ANNUAL REPORT TO THE GENERAL
22 ASSEMBLY REGARDING THE IMPLEMENTATION, OPERATION AND ENFORCEMENT
23 OF THIS ARTICLE.

24 SECTION 2182. PENALTIES AND SANCTIONS.--(A) THE DEPARTMENT
25 [OR THE INSURANCE DEPARTMENT, AS APPROPRIATE,] MAY IMPOSE A
26 CIVIL PENALTY OF UP TO FIVE THOUSAND (\$5,000) DOLLARS FOR A
27 VIOLATION OF THIS ARTICLE.

28 (B) [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN SHALL BE
29 SUBJECT TO THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS
30 THE "UNFAIR INSURANCE PRACTICES ACT."

1 (C) THE DEPARTMENT [OR THE INSURANCE DEPARTMENT] MAY
2 MAINTAIN AN ACTION IN THE NAME OF THE COMMONWEALTH FOR AN
3 INJUNCTION TO PROHIBIT ANY ACTIVITY WHICH VIOLATES THE
4 PROVISIONS OF THIS ARTICLE.

5 (D) THE DEPARTMENT MAY ISSUE AN ORDER TEMPORARILY
6 PROHIBITING [A] AN INSURER OR MA OR CHIP MANAGED CARE PLAN WHICH
7 VIOLATES THIS ARTICLE FROM ENROLLING NEW [MEMBERS] COVERED
8 PERSONS OR ENROLLEES.

9 (E) THE DEPARTMENT MAY REQUIRE [A] AN INSURER OR MA OR CHIP
10 MANAGED CARE PLAN TO DEVELOP AND ADHERE TO A PLAN OF CORRECTION
11 APPROVED BY THE DEPARTMENT. THE DEPARTMENT SHALL MONITOR
12 COMPLIANCE WITH THE PLAN OF CORRECTION. THE PLAN OF CORRECTION
13 SHALL BE AVAILABLE TO COVERED PERSONS OR ENROLLEES OF THE
14 INSURER OR MA OR CHIP MANAGED CARE PLAN UPON REQUEST.

15 [(F) IN NO EVENT SHALL THE DEPARTMENT AND THE INSURANCE
16 DEPARTMENT IMPOSE A PENALTY FOR THE SAME VIOLATION.]

17 SECTION 9. THE ACT IS AMENDED BY ADDING A SECTION TO READ:
18 SECTION 2184. REGULATIONS.--THE DEPARTMENT MAY PROMULGATE
19 REGULATIONS AS NECESSARY AND APPROPRIATE TO CARRY OUT THE
20 PROVISIONS OF THIS ARTICLE.

21 SECTION 10. SECTIONS 2191 AND 2192(4) OF THE ACT ARE AMENDED
22 TO READ:

23 SECTION 2191. COMPLIANCE WITH NATIONAL ACCREDITING
24 STANDARDS.--NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE
25 TO THE CONTRARY, THE DEPARTMENT SHALL GIVE CONSIDERATION TO [A]
26 AN INSURER'S OR MA OR CHIP MANAGED CARE PLAN'S DEMONSTRATED
27 COMPLIANCE WITH THE STANDARDS AND REQUIREMENTS SET FORTH IN THE
28 "STANDARDS FOR THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS"
29 PUBLISHED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR
30 OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS IN

1 DETERMINING COMPLIANCE WITH THE SAME OR SIMILAR PROVISIONS OF
2 THIS ARTICLE. THE INSURER OR MA OR CHIP MANAGED CARE PLAN,
3 HOWEVER, SHALL REMAIN SUBJECT TO AND SHALL COMPLY WITH ANY OTHER
4 PROVISIONS OF THIS ARTICLE THAT EXCEED OR ARE NOT INCLUDED IN
5 THE STANDARDS OF THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR
6 OTHER DEPARTMENT-APPROVED QUALITY REVIEW ORGANIZATIONS.

7 SECTION 2192. EXCEPTIONS.--THIS ARTICLE SHALL NOT APPLY TO
8 ANY OF THE FOLLOWING:

9 * * *

10 (4) THE FEE-FOR-SERVICE PROGRAMS OPERATED BY THE DEPARTMENT
11 OF [PUBLIC WELFARE] HUMAN SERVICES UNDER TITLE XIX OF THE SOCIAL
12 SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396 ET SEQ.).

13 SECTION 11. REPEALS ARE AS FOLLOWS:

14 (1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEALS UNDER
15 PARAGRAPH (2) ARE NECESSARY TO EFFECTUATE THIS ACT.

16 (2) THE FOLLOWING ACTS AND PARTS OF ACTS ARE REPEALED TO
17 THE EXTENT SPECIFIED:

18 (I) SECTION 630(E) AND (F) OF THE ACT, INsofar AS
19 THEY ARE INCONSISTENT WITH THIS ACT.

20 (II) THE ACT OF DECEMBER 29, 1972 (P.L.1701,
21 NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION
22 ACT, INsofar AS IT IS INCONSISTENT WITH THIS ACT.

23 (III) 40 PA.C.S. CH. 61, INsofar AS IT IS
24 INCONSISTENT WITH THIS ACT.

25 (IV) 40 PA.C.S. CH. 63, INsofar AS IT IS
26 INCONSISTENT WITH THIS ACT.

27 (V) ALL OTHER PARTS OF THIS ACT ARE REPEALED INsofar
28 AS THEY ARE INCONSISTENT WITH THIS ACT.

29 SECTION 12. CONTINUATION IS AS FOLLOWS:

30 (1) EXCEPT AS OTHERWISE REQUIRED TO COMPLY WITH THIS

1 ACT, ACTIVITIES INITIATED UNDER ARTICLE XXI OF THE ACT PRIOR
2 TO THE EFFECTIVE DATE OF THIS SECTION SHALL CONTINUE AND
3 REMAIN IN FULL FORCE AND EFFECT AND MAY BE COMPLETED UNDER
4 ARTICLE XXI OF THE ACT ON AND AFTER THE EFFECTIVE DATE OF
5 THIS SECTION.

6 (2) CONTRACTS AND OBLIGATIONS ENTERED INTO UNDER ARTICLE
7 XXI OF THE ACT PRIOR TO THE EFFECTIVE DATE OF THIS SECTION
8 SHALL NOT BE AFFECTED OR IMPAIRED BY THIS ACT.

9 (3) ORDERS, REGULATIONS, RULES AND DECISIONS OF THE
10 DEPARTMENT OF HEALTH WHICH WERE MADE UNDER ARTICLE XXI OF THE
11 ACT PRIOR TO THE EFFECTIVE DATE OF THIS SECTION AND WHICH ARE
12 IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION SHALL REMAIN
13 IN FULL FORCE AND EFFECT AND SHALL BE ENFORCED BY THE
14 DEPARTMENT UNTIL REVOKED, VACATED OR MODIFIED BY THE
15 DEPARTMENT UNDER ARTICLE XXI OF THE ACT.

16 SECTION 13. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

17 (1) THE FOLLOWING PROVISIONS SHALL TAKE EFFECT
18 IMMEDIATELY:

19 (I) SECTION 11 OF THIS ACT.

20 (II) SECTION 12 OF THIS ACT.

21 (III) THIS SECTION.

22 (2) THE ADDITION OF SECTION 2153 OF THE ACT SHALL TAKE
23 EFFECT JANUARY 1, 2023.

24 (3) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT JANUARY
25 1, 2024.