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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1293 Session of 2017

INTRODUCED BY M. QUINN, BAKER, BERNSTINE, BOBACK, CHARLTON, CORR, COX, DAVIS, DeLUCA, DiGIROLAMO, DRISCOLL, FEE, FRANKEL, GILLEN, GODSHALL, A. HARRIS, HELM, PHILLIPS-HILL, JOZWIAK, KNOWLES, LEWIS, LONGIETTI, MACKENZIE, MALONEY, MASSER, MILLARD, MUSTIO, NESBIT, PETRI, RADER, ROZZI, RYAN, SANTORA, SAYLOR, SOLOMON, STURLA, WARD, WARREN, WATSON, WHEELAND AND SIMS, MAY 1, 2017

REFERRED TO COMMITTEE ON INSURANCE, MAY 1, 2017

AN ACT

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

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

Section 1. Short title.

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

Section 2. Declaration of policy.

The General Assembly finds and declares as follows:

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

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

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

or available, appropriate use criteria or written clinical criteria.

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

Section 3. Definitions.

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

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

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

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

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

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

"Appropriate use criteria." Criteria that:

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

(2) is derived from documents from professional

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

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

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

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

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

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

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

(2) serious impairment to bodily function; or

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

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

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

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

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

(1) a facility licensed in this Commonwealth;

(2) a doctor of medicine or a doctor of osteopathy; or

(3) the scope of practice for which a health care practitioner is licensed in this Commonwealth.

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

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

(1) in accordance with generally accepted standards of medical practice;

(2) clinically appropriate in terms of type, frequency, extent, site and duration; and

(3) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care practitioner.

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

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

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

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

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

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

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

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

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

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

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

(2) an insurer that writes health insurance policies;

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

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

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

Section 4. Basis, development and use.

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

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

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

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

(2) Applied consistently.

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

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

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

(1) Be based on nationally recognized standards.

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

(3) Reflect community standards of care.

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

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

expert consensus standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Written clinical criteria for preauthorization decisions.

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

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

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

A utilization review entity shall ensure that:

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

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

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

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

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

(1) The specific health care services preauthorized.

(2) The next date for review.

(3) The total number of days approved.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 10. Notifications of adverse determinations.

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

Section 11. Reviews of appeals.

(a) Expedited appeals.--

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

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

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

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

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

medical condition or disease.

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

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

(5) Not involved in making the adverse determination.

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

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

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

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

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

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

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

(d) Deadlines.--

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

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

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

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

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

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

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

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

Section 13. Limitation on requests for medical records.

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

Section 14. Preauthorization by secondary payers.

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

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

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

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

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

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

Section 16. Effect of noncompliance.

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

Section 17. Uniform preauthorization form.

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

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

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

Section 18. Exemption.

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

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

Section 19. Effective date.

This act shall take effect in 60 days.