THOMSON, RHODES & COWIE, P.C.
MANAGED CARE LAW UPDATE

Volume II, Issue 8 September 1999 Page 1 of 2

STATE NEWS

PA Insurance Department Issues Act 68 Proposed Regulations. On July 31, 1999, the Pennsylvania Department of Insurance issued proposed regulations applicable to the Quality Health Care Accountability and Protection Act, 40 P.S. §991.2101 – 991.2193, commonly known as Act 68. The proposed regulations, when adopted, will supercede the statement of policy issued in December of 1998, 31 Pa. Code §301.401 et. seq. The proposed regulations expand upon the statement of policy, and apply not only to managed care plans, themselves, but also to subcontractors of managed care plans providing services to enrollees.

The proposed regulations require each managed care plan to adopt and maintain procedures by which an enrollee with a life threatening, degenerative or disabling disease or condition may receive either a standing referral to a specialist or designation of a specialist as the primary care provider. The plan's standards may include time restrictions on standing referrals or specialist designations.

Managed care plans must also permit enrollees direct access to obstetrical and gynecological services from participating health care providers without prior approval of the primary care provider. The directly accessed provider must inform the enrollee's primary care provider of all health care services provided to the enrollee within thirty (30) days of the date of service.

Managed care plans are also prohibited from requiring enrollees or health care providers to obtain prior authorization for emergency services and are required to pay all reasonably necessary costs associated with any emergency services provided during the period of emergency. If the enrollee is admitted to a health care facility, the emergency care provider must notify the plan of the emergency services delivered within forty-eight (48) hours or the next business day, whichever is later. If the enrollee is not admitted to a hospital, the claim for reimbursement for emergency services is deemed to be sufficient notice. The regulations also include detailed disclosure requirements, which include a notice to enrollees that emergency services are not subject to prior approval.

The proposed regulations also expand and clarify the continuity of care requirements. Current enrollees are allowed to continue ongoing treatment with a provider whose contract has been terminated for reasons other than cause for a period of up to sixty days from the date the enrollee was notified by the plan of the termination or pending termination. Enrollees in the second or third trimester of pregnancy are permitted a transitional period through the end of post-partum care. New enrollees may obtain a similar transitional treatment benefit from a non-participating provider upon joining a managed care plan. In either case, providers of transitional treatment must agree to the plan's terms and conditions for payment. Managed care plans may not require non-participating providers to undergo the plans' credentialing process as part of the continuity of care provision.

One part of the regulations which will surely result in great confusion has to do with the jurisdictional battle between complaints and grievances. The complaint process, administered by the Department of Insurance, covers issues of contract

(Continued on page 2)

Thomson, Rhodes & Cowie, P.C., Health Care Law Section, Two Chatham Center, Tenth Floor, Pittsburgh, PA 15219

For additional information, please contact Jerry R. Hogenmiller, Esquire at (412)232-3400

(Continued from page 1)

exclusions and non-covered benefit disputes. The grievance process, administered by the Department of Health, includes review of the medical necessity and appropriateness of services otherwise covered by the managed care plan. For example, a dispute over a provider's refusal to refer an enrollee to a specialist based on lack of medical necessity would be considered a grievance. A denial of payment for a specialist visit on the grounds that the enrollee did not obtain the necessary authorization would be considered a complaint. Other examples of complaints include problems related to coordination of benefits, subrogation, conversion coverage, alleged non-payment of premium, dependent coverage and involuntary disenrollment.

Although the proposed regulations govern only the complaint process, they permit managed care plans to establish time frames of at least thirty (30) days for the filing of both complaints and grievances. The proposed regulations require each managed care plan to establish an internal complaint process with two levels of review and to allow enrollees to file oral and written complaints. The initial level of review must be completed within thirty (30) days of receipt of the complaint and the enrollee must be notified of the plan's decision within five (5) business days. The second level of review must be completed within forty-five (45) days of receipt of the enrollee's request for review and the enrollee must be notified within five (5) business days of the plain's decision. Enrollees must complete the plan's internal complaint process before filing an appeal, which must be submitted to the Department of Insurance within fifteen (15) days of receipt of notice of the second level review committee's decision.

The proposed regulations implement the prompt payment requirements of Act 68 by requiring payment within forty-five (45) days of receipt of a clean claim. The proposed regulations define "clean claim" as "a claim for payment for a health care service which has no defect or inpropriety . . . ." A "defect or inpropriety" includes lack of required substantiating documentation or a particular circumstance which requires special treatment. Clean claims do not include claims from a health care provider who is under investigation for fraud or abuse regarding the claim at issue. If a paid claim is readjudicated, the forty-five (45) day period for prompt payment begins again at the time additional information prompting the readjudication is provided to the plan.

The Insurance Department's proposed regulations tell only half the story. The Department of Health's Act 68 regulations are anticipated later this month. Stay tuned to the Managed Care Law Update for information. If you would like a copy of the proposed Insurance Department Regulations please contact Jim Rogers or Jane Charlton at Thomson, Rhodes & Cowie, P.C., (412) 232-3400.

FEDERAL NEWS

Final Civil Monetary Penalty Rules Issued. On July 22, 1998, the U.S. Department of Health and Human Services issued its final rule regarding the civil monetary penalties that may be imposed against providers involved in health care fraud. The rule broadens the authority of the Office of Inspector General (OIG) to exclude individuals and entities from Medicare, Medicaid and all other federal health care programs and strengthens the OIG's legal authority to impose civil monetary penalties. The final rule authorizes the assessment of penalties of up to $10,000 against institutional health care providers that knowingly employ or enter into contracts for medical services with excluded individuals. In addition, there is a new penalty of up to $25,000 for health plans that fail to report information to the Health Care Integrity and Protection Data Bank (not effective until the issuance of final HIPDA regulations.) This regulation also authorizes the imposition of penalties of up to $50,000 per violation of the Anti-kickback Act with a maximum penalty amount of not more than three times the amount of the remuneration offered, paid, solicited or received in the kickback scheme.

In related news, the OIG announced on July 28th that it will seek a new civil penalty of up to $10,000 for each instance of a hospital's failure to report an adverse action against a physician to the National Practitioner Data Bank. The OIG claims that the new civil penalty is necessary due to documented non-reporting of adverse actions by hospitals.