Technical Advisory Interpreting 28 Pa. Code §9.753 (Relating to Time Frames for UR) -- Communicating the UR Decision

On February 24,2004, the Bureau of Managed Care initiated a compliance audit of managed care plan performance against the standards for utilization review (UR) established by Article XXI of the Insurance Company Law of 1921 (40 P.S. §§991.2101-991.2193), commonly referred to as "Act 68," and the Department of Health's Managed Care Regulations at 28 Pa. Code §§ 9.752 and 9.753 (relating to UR system standards; Time frames for UR).

Aggregate findings from the utilization review audit of Pennsylvania managed care plans suggested that many plans were out of compliance with several requirements. One of the most common areas of noncompliance was related to the specific requirements for communicating UR decisions to enrollees and providers.

In order to help plans implement an effective Plan of Correction (POC) to address this particular area of noncompliance, the Bureau was asked to provide regulatory guidance for plans responding to this finding. The Bureau has developed the following Technical Advisory to provide managed care plans with the Bureau's interpretation of its regulation and to aid the plans in achieving compliance with this standard.

1. The requirements for plan communication of utilization review decisions in preauthorization and concurrent review situations, as required at subsection 9.753(a), (b) and (c), will be determined to be met, if written notice is faxed to the provider within the required time frame for communicating the decision. There must be confirmation of the time, date and content of the fax in the UR file.

An actual phone call communicating the decision to the provider's office is also adequate to meet the communication requirement, as long as that call is documented in the file as to time, date and content of the message and also identifies the person to whom the message was given. If there is no documentation in the file of the completed call, or fax communication to the provider in the file, then the case is in violation of the requirements for communication of the UR decision.

2. Mailing the written decision letter via regular mail in preauthorization or concurrent review situations does not satisfy the requirement to communicate the decision within the required time frames for prospective or concurrent utilization review. Mailing a letter does not assure that the enrollee and/or provider receives the decision within the 1 business day/ 2 business day time frames for communicating decisions; therefore, the Department has determined that such regular mail notice does not meet the "communication" requirement standard established by Act 68 and the managed care regulations. Acceptable "communication" of the decision within the context of the Managed Care Regulations means the decision has been sent by the plan and received by the enrollee and/or the provider accordingly within the required time frame.

3. Some plans have advised that they only communicate UR decisions to providers and not to members within the initial communication timeframe. This is acceptable in those instances where the Plan is working under an acknowledged assumption that the provider will be responsible for communicating this information to the patient. If the plan relies solely on the provider to facilitate this communication, the plan will continue to be held accountable for notice, or lack thereof, to the enrollee, based on the provider's performance of this responsibility for notice and documentation of the provision of such notice to the enrollee.

In instances of approvals, the plan is not required to automatically send a written confirmation to the enrollee, if the enrollee will be given written notice of the confirmation from the provider. This would be the case with provider-issued referral forms. Should the plan choose to rely on the provider for communicating approvals of coverage, the plan will be held responsible for the clarity and accuracy of the provider's communication.

4. For situations in which the review is retrospective and when the enrollee is typically held harmless, the written notice of the UR decision may go out anytime within the 45-day decision and notice time frame (30 days+15 days). Written notice to the provider is sufficient to meet the "communicated" requirement for retrospective situations, so long as it was mailed within this 45-day timeframe. The Department will not require notice to enrollees in retrospective review "hold harmless" situations, and is not suggesting that it should occur.

Comments, suggestions or questions should be directed to the Bureau of Managed Care at phone 717-787-5193 or in writing to the attention of Stacy Mitchell, Director, Bureau of Managed Care, 912 Health and Welfare Building, Harrisburg, PA 17120