# CHAPTER 154. QUALITY HEALTH CARE ACCOUNTABILITY AND PROTECTION

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**Authority**

The provisions of this Chapter 154 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and section 320 of The Insurance Department Act of 1921 (40 P. S. § 443); and section 2181 of The Insurance Company Law (40 P. S. § 991.2181), unless otherwise noted.

**Source**

The provisions of this Chapter 154 adopted March 10, 2000, effective March 11, 2000, 30 Pa.B. 1453, unless otherwise noted.

**Cross References**

This chapter cited in 28 Pa. Code § 9.601 (relating to applicability).

## GENERAL PROVISIONS

### § 154.1. Applicability and purpose.

(a) This chapter governs quality health care accountability and protection and applies to managed care plans and licensed insurers subject to the act. The Department and the Department of Health both have regulatory authority under the act. This chapter does not apply to health care services and claims processed under automobile and worker's compensation policies.

(b) The terms and conditions of group and individual contract renewals and new business written by managed care plans on or after January 1, 1999, shall conform to the act.

(c) An entity, including an IDS, subcontracting with a managed care plan to provide services to enrollees shall meet the requirements of the act and this chapter for services provided to those enrollees.

(d) Policies which partially insure an entity's risk, shall meet the requirements of the act if they are issued by a managed care plan.

## § 154.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

*Act*—Article XXI of The Insurance Company Law of 1921 (40 P. S. §§ 991.2101—991.2193).

*Ancillary service plan*—As defined in section 2102 of the act (40 P. S. § 991.2102).

*Clean claim*—As defined in section 2102 of the act.

*Commissioner*—The Insurance Commissioner of the Commonwealth.

*Complaint*—As defined in section 2102 of the act.

*Department*—The Insurance Department of the Commonwealth.

*Emergency service*—As defined in section 2102 of the act.

*Enrollee*—A policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan. For purposes of the complaint and grievance processes, the term includes parents of minor enrollees as well as designees or legal representatives who are entitled or authorized to act on behalf of an enrollee.

*Gatekeeper*—A primary care provider selected by an enrollee or appointed by a managed care plan, or the plan or an agent of the plan serving as the primary care provider, from whom an enrollee shall obtain covered health care services, a referral, or approval for covered, nonemergency health services as a precondition to receiving the highest level of coverage available under the managed care plan.

*Grievance*—As defined in section 2102 of the act.

*Health care provider*—As defined in section 2102 of the act.

*Health care service*—As defined in section 2102 of the act.

*IDS—Integrated Delivery System*—

(i) A partnership, association, corporation or other legal entity which does the following:

(A) Enters into a contractual arrangement with a managed care plan.

(B) Employs or has contracts with providers (participating providers).

(C) Agrees under its arrangements with a managed care plan to do the following:

(I) Provide or arrange for the provision of a defined set of health care services to managed care plan members covered under a managed care plan benefits contract principally through its participating providers.

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(II) Assume under the arrangements some responsibility for conduct, in conjunction with the managed care plan and under compliance monitoring of the managed care plan's quality assurance, utilization review, credentialing, provider relations or related functions.

(ii) The IDS may also perform claims processing and other functions.

*Licensed insurer*—An individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer and other legal entity engaged in the business of insurance, and fraternal benefit societies as defined in the Fraternal Benefits Societies Code (40 P. S. §§ 1142-101—1142-701), and preferred provider organizations as defined in section 630 of The Insurance Company Law of 1921 (40 P. S. § 764a) and § 152.2 (relating to definitions).

*Managed care plan*—

(i) A health care plan that: uses a gatekeeper to manage the utilization of health care services; integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards; and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(A) Section 630 of The Insurance Company Law of 1921.

(B) The Health Maintenance Organization Act (40 P. S. §§ 1551—1568).

(C) The Fraternal Benefit Societies Code.

(D) 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations).

(E) 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations).

(ii) 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.

(iii) The term includes managed care plans that require the enrollee to obtain a referral from any primary care provider in its network as a condition to receiving the highest level of benefits for specialty care.

(iv) The term does not include ancillary service plans as defined by the act or an indemnity arrangement which is primarily fee for service.

*Ongoing course of treatment*—A continuous health care treatment provided to an enrollee by a health care provider which was initiated prior to and that will continue after the plan's termination of a contract with a participating provider for reasons other than cause or the enrollee's coverage by a managed care plan as a new enrollee.

*Plan*—As defined in section 2102 of the act.

*Primary care provider*—As defined in section 2102 of the act.

*Prospective enrollee*—For group contracts or policies, those persons eligible, but not yet enrolled, for coverage as either a subscriber or dependent of a sub-

scriber. For individual contracts or policies, a person who meets the eligibility requirements of the managed care plan.

*Provider network*—As defined in section 2102 of the act.

*Referral*—As defined in section 2102 of the act.

*Utilization review*—As defined in section 2102 of the act.

*Utilization review entity*—As defined in section 2102 of the act.

## § 154.3. Changes, modifications and disclosures in subscriber and other contracts and in other materials.

Managed care plans shall implement changes, modifications and disclosures to subscriber and other contracts, marketing materials, member handbooks and other appropriate materials to meet the requirements of the act. Modifications can be implemented in several different ways including contract endorsements, contract amendments and modification to the contract then in effect.

## REQUIRED PROVISIONS AND ENROLLEE DISCLOSURES

## § 154.11. Managed care plan requirements.

(a) Managed care plans shall 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 established standards are met, be permitted to receive approval for either:

(1) A standing referral to a specialist with clinical expertise in treating the disease or condition.

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

(b) A managed care plan's established standards, as referenced in subsection (a) may include:

(1) Time restrictions on approved treatment plans, as set forth in section 2111(6) of the act (40 P. S. § 991.2111(6)), which include standing referrals or specialist designations.

(2) Requirements that treatment plans be periodically reviewed and reapproved by the plan.

(3) Requirements that the specialist notify the enrollee's primary care provider of all care provided within 30 days.

## § 154.12. Direct enrollee access to obstetrical and gynecological services.

(a) Managed care plans shall permit enrollees direct access to obstetrical and gynecological services for maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals, for diagnostic testing related to maternity and gynecological care from participating health care providers without prior approval from a primary care provider. No time restrictions shall apply to the direct accessing of these services by enrollees.





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(b) A managed care plan may require a provider of obstetrical or gynecological services to obtain prior authorization for selected services such as diagnostic testing or subspecialty care—for example, reproductive endocrinology, oncologic gynecology and maternal and fetal medicine.

(c) A directly accessed participating health care provider providing services to an enrollee who has direct access to the provider in accordance with section 2111(7) of the act (40 P. S. § 991.2111(7)) and this section, shall inform the enrollee's primary care provider, of all health care services provided to the enrollee. The health care provider shall communicate the information within 30 days of the services being provided under procedures established by the managed care plan. For routine obstetrical services, an initial notification and final notification, subsequent to the postpartum visit, shall meet the notification requirements.

(d) Managed care plans may not have different reimbursement levels for covered services because an enrollee obtains these services through direct access rather than with the prior approval of a primary care provider.

## § 154.13. Managed care plan reporting of complaints and grievances.

(a) Section 2111(13) of the act (40 P. S. § 991.2111(13)) requires managed care plans to report specific information to the Department of Health and the Department with respect to the number, type and disposition of all complaints and grievances filed with the managed care plan.

(b) Managed care plans shall report the information in subsection (a) to the Departments based on the format as required by the Departments.

(c) Notice of changes or amendments to the format for reporting complaint and grievance information will be published by the Department in the *Pennsylvania Bulletin.* The notice will provide for a 30-day public comment period. Changes in format will become effective 30 days after publication of the revised format in a subsequent edition of the *Pennsylvania Bulletin.*

## § 154.14. Emergency services.

(a) Managed care plans are prohibited from requiring that enrollees or health care providers obtain prior authorization for emergency services as defined by section 2102 of the act (40 P. S. § 991.2102).

(b) Plans are required to pay all reasonably necessary costs for enrollees meeting the prudent layperson definition of emergency services provided during the period of the emergency, including evaluation, testing, and if necessary, the stabilization of the condition of the enrollee.

(c) Sudden and unexpected medical events involving a chronic condition which meet the prudent layperson requirements of the act shall be considered emergency services subject to the act and this chapter.



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(d) Plans are required to consider the presenting symptoms as documented by the claim file, and the services provided, when processing claims for emergency services.

(e) The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee.

(1) If the enrollee is admitted to a hospital or other health care facility, the emergency health care provider shall notify the enrollee's managed care plan of the emergency services delivered within 48 hours or on the next business day, whichever is later. An exception to this requirement will be made where the medical condition of the patient precludes the provider from accurately determining the identity of the enrollee's managed care plans within 48 hours of admission.

(2) If the enrollee is not admitted to a hospital or other health care facility, the claim for reimbursement for emergency services provided shall serve as notice to the enrollee's managed care plan of the emergency services provided by the emergency health care provider.

(f) Managed care plans shall supply each enrollee, and upon written request, each prospective enrollee or health care provider, with the information concerning emergency services in § 154.16(h) (relating to information for enrollees).

## § 154.15. Continuity of care.

(a) Managed care plans are required to provide the option of continuity of care for enrollees when one of the following applies:

(1) A managed care plan terminates a contract with a participating provider for reasons other than for cause as set forth in section 2117(b) of the act (40 P. S. § 991.2117(b)) and the enrollee is then in an ongoing course of treatment with that provider.

(2) A new enrollee enters a managed care plan and is then in an ongoing course of treatment with a nonparticipating provider which is not otherwise covered by the terminated coverage.

(b) A current enrollee shall be allowed to continue an ongoing course of treatment with a provider whose contract has been terminated by the plan for reasons other than for cause (as set forth in section 2117(b) of the act) for a transitional period of up to 60 days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. For 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 be extended through postpartum care related to the delivery.

(c) A new enrollee shall be allowed to continue an ongoing course of treatment with a nonparticipating provider when joining a managed care plan for a



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transitional period of up to 60 days from the effective date of enrollment in the managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. For an enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall be extended through postpartum care related to the delivery.

(d) Continuity of care is at the option of the enrollee.

(e) Nonparticipating and terminated providers may be required by the plan to agree to the same terms and conditions which are applicable to the managed care plan's participating providers. If multiple providers are involved in an ongoing course of treatment, one of the following conditions shall be met:

(1) All of the providers involved may be required by the plan to agree to the plan's terms and conditions.

(2) Those providers who accept the plan's terms and conditions may be required by the plan to agree to utilize participating providers for the provision of all other health care services to enrollees.

(f) Health care services provided under the continuity of care requirements shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers. To be eligible for payment by plans, providers shall agree to the terms and conditions of the managed care plan prior to providing service under the continuity of care provisions.

(g) Managed care plans may require nonparticipating or terminating providers to agree to terms that include:

(1) Accepting the plan's payment as payment in full for covered services, without balance billing, except for permitted deductibles, copayments or coinsurance.

(2) Agreeing to hold the enrollee harmless for any moneys which may be owed by the managed care plan to the provider.

(3) Complying with the plan's utilization review and quality assurance requirements.

(4) Agreeing that the provider will provide copies of the enrollee's medical records to the plan or the enrollee's participating primary care provider, or both, prior to the conclusion of the ongoing course of previously authorized treatment.

(5) Agreeing to follow the plan's procedures for precertification or prior approval of specified nonemergency services or procedures.

(h) Managed care plans may not require nonparticipating providers to undergo the full plan's credentialing process as part of the continuity of care provision.

(i) Written disclosure of the continuity of care benefit requirements imposed under the act and this chapter shall be incorporated into the subscriber and master group contracts and the enrollee handbook (if provided to the enrollee). This information and other information necessary to provide continuity of care ser-

vices shall also be provided in written form to terminated or terminating and nonparticipating providers within 10 days of notice to the plan that an enrollee is requesting continuity of care benefits.

## § 154.16. Information for enrollees.

(a) Managed care plans shall provide the written information in section 2136(a) of the act (40 P. S. § 991.2136(a)), which relates required disclosures, to enrollees and, on written request, to prospective enrollees and health care providers.

(1) Managed care plans may determine the format for disclosure of the required information. If the information is disclosed through materials such as subscriber contracts, schedules of benefits and enrollee handbooks, the information shall be easily identifiable within the materials provided.

(2) The written information to be provided by managed care plans to enrollees, prospective enrollees and health care providers shall be subject to the filing requirements under the Accident and Health Filing Reform Act (40 P. S. §§ 3801—3813) and all other applicable statutes and regulations.

(b) The information disclosed to enrollees, prospective enrollees and health care providers shall be easily understandable to the layperson.

(c) The written disclosure of information shall include:

(1) The information required by subsection (a).

(2) A list by specialty of the name, address and telephone number of all participating health care providers which an enrollee may have access to either directly or through a referral. The list may be a separate document and may be a regional or county directory and shall be updated at least annually. If a regional or county directory is provided, enrollees shall be made aware that other regional or a full directory is available upon request. If a list of participating providers for only a specific type of provider or service is provided, it shall include all participating providers authorized to provide those services.

(3) The information covered under section 2113(d)(2)(ii) of the act (40 P. S. § 991.2113(d)(2)(ii)), which relates to a medical ''gag clause'' prohibition.

(4) If applicable, managed care plans shall disclose in their subscriber contracts, schedule of benefits and other appropriate material, circumstances under which the managed care plan does not provide for, reimburse for or cover counseling, referral or other health care services due to a managed care plan's objections to the provision of the services on moral or religious grounds.

(d) For the purposes of the specified disclosure statement required by section 2136(a)(1) of the act, subscriber and group master contracts and riders, amendments and endorsements, do not constitute ''marketing materials'' subject to the specified disclosure statement. For the purposes of written information distributed



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to enrollees or potential enrollees, the term ''marketing materials'' shall have the meaning given to written information in the term ''advertisement'' in § 51.1 (relating to definitions).

(e) For group contracts and policies, the managed care plan shall assure that the required disclosure information is provided to prospective enrollees upon written request. The managed care plan can either provide the information directly to prospective enrollees or allow the group policy holder or another entity to provide the information to prospective enrollees on behalf of the managed care plan.

(f) For individual contracts and policies, the managed care plan shall provide the required disclosure information directly to prospective enrollees upon written request.

(g) The disclosure of information to enrollees, prospective enrollees and health care providers as required by section 2136 of the act shall be provided as follows:

(1) During open enrollment periods managed care plans may disclose summary information to enrollees and prospective enrollees. If the disclosure of information does not include all the information required by the act and this chapter, the managed care plan shall simultaneously provide enrollees and prospective enrollees with a list of other information which has not been included with the open enrollment information. The listed information shall be made available to enrollees and prospective enrollees upon request.

(2) Following initial enrollment, or upon renewal, if benefits have changed or networks have substantially changed since the initial enrollment or last renewal, disclosure information shall be provided to enrollees within 30 days of the effective date of the contract or policy, renewal date of coverage, if appropriate, or the date of receipt of the request for the information.

(3) Disclosure information requested by prospective enrollees shall be provided to prospective enrollees within 30 days of the date of the receipt of the written request for the information.

(4) Disclosure information requested by health care providers shall be provided to health care providers within 45 days of the date of the receipt of the written request for the information.

(h) Managed care plans shall supply each enrollee, and upon written request, each prospective enrollee or health care provider, with the following information which shall be contained and incorporated into subscriber and master group contracts:

(1) A description of the procedures for providing emergency services 24 hours a day.

(2) A definition of ''emergency services,'' as set forth in the act.

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

(4) The enrollee's financial and other responsibilities regarding emergency services, including the receipt of these services outside the managed care plan's service area.

(i) Managed care plans, upon written request by enrollees or prospective enrollees, shall provide written information as specified in section 2136(b) of the act. This information shall be easily understandable to the layperson.

**Cross References**

This section cited in 28 Pa. Code § 9.653 (relating to HMO provision of limited subnetworks to select enrollees); 28 Pa. Code § 9.681 (relating to health care providers); and 31 Pa. Code § 154.14 (relating to emergency services).

## § 154.17. Complaints.

(a) Under the complaint process established by sections 2141—2143 of the act (40 P. S. §§ 991.2141—991.2143), the Department will consider complaints including those regarding issues of contract exclusions, noncovered benefit disputes and potential violation of insurance statutes, including the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15). The enrollee may be represented by an attorney or other individual before the Department. The Department of Health will focus on complaint issues including those involving enrollee quality of care and quality of service. The grievance process, which is administered by the Department of Health, includes review of the medical necessity and appropriateness of services otherwise covered by the managed care plan. Examples of the types of complaints which may be filed with the Department include:

(1) Denial of payment by the plan based upon contractual limitation rather than on medical necessity—for example, denial of payment for a visit by an enrollee on the basis that the enrollee failed to meet the contractual requirement of obtaining a referral from a primary care provider. However, a primary care provider's refusal to make an enrollee referral to a specialist, on the basis that the referral is not medically necessary, would be considered a grievance.

(2) Disputes involving a noncovered benefit or contract exclusion—for example, a request for additional physical therapy services, even if medically necessary, beyond the number specified in the enrollee contract.

(3) Problems relating to one or more of the following:

(i) Coordination of benefits.

(ii) Subrogation.

(iii) Conversion coverage.

(iv) Alleged nonpayment of premium.

(v) Dependent coverage.

(vi) Involuntary disenrollment.

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(b) Managed care plans shall establish an internal complaint process with two levels of review to allow enrollees to file oral and written complaints regarding a participating health care provider or the coverage, operations or management policies of the plan.

(c) Inquiries, complaints and questions regarding premium rate increases may be filed with the Department without the necessity of following the plan's internal complaint process.

(d) If plans establish time frames for the filing of complaints and grievances with the plan, they shall allow the enrollees at least 45 days to file a complaint or grievance from the date of the occurrence of the issue being complained about or the date of the enrollees' receipt of notice of the plan's decision.

(e) Managed care plans shall complete the initial level of review of an enrollee complaint within 30 days of receipt of the complaint. The plan shall notify the enrollee in writing of the plan's decision following the initial review within 5 business days of the decision. The notification 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.

(f) Managed care plans shall complete the second level of review of an enrollee complaint within 45 days of receipt of the enrollee's request for review. The enrollee has the right to appear before the second level review committee. The plan shall notify the enrollee in writing within 5 business days of the rendering of a decision by the second level complaint review committee, including the basis for the decision and the procedure for appealing the decision to the Department.

(g) To expedite the complaint review process, enrollees should follow and complete the plan's internal complaint process before filing an appeal of the complaint decision with the Department or the Department of Health. Under section 2143 of the act (40 P. S. § 991.2143), the Department may communicate with the appropriate parties to assist in the resolution of the complaint.

(h) Appeals of complaints shall be submitted to the Department within 15 days of receipt of notice of the second level review committee's decision.

(i) Appeals of complaints to the Department shall include the following information:

(1) The enrollee's name, address and daytime phone number.

(2) The enrollee's policy number, identification number and group number (if applicable).

(3) A copy of the complaint submitted to the managed care plan.

(4) The reasons for appealing the managed care plan's decision.

(5) Correspondence and decisions from the managed care plan regarding the complaint.

(6) Whether the enrollee will be represented by an attorney or other individual before the Department.

(j) The Department will notify the plan if a complaint appeal has been filed. The plan shall provide copies of all records from the initial and second level review to the Department. This information shall be provided to the Department within 30 days of the Department's notice to the plan of the complaint appeal.

(k) When an appeal is transferred from the Department to the Department of Health, the original submission date of the appeal will be utilized to determine compliance with the filing time frame in accordance with section 2142(a) of the act (40 P. S. § 991.2142(a)), which relates to the appeal of a complaint. The Department will notify the enrollee and the managed care plan in writing and promptly transmit the appeal to the Department of Health for consideration.

(l) The Department will provide the managed care plan and the enrollee with a copy of the final determination of an appealed complaint.

(m) Complaint appeals under subsection (i) may be filed with the Department at the following address:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, Pennsylvania 17120

**Cross References**

This section cited in 28 Pa. Code § 9.703 (relating to internal complaint process).

## § 154.18. Prompt payment.

(a) Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services provided on or after January 1, 1999, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The prompt payment provision applies only to claims submitted under health insurance policies, excluding areas such as automobile and worker's compensation policies.

(b) For purposes of prompt payment, a claim shall be deemed to have been ''paid'' upon one of the following:

(1) A check is mailed by the licensed insurer or managed care plan to the health care provider.

(2) An electronic transfer of funds is made from the licensed insurer or managed care plan to the health care provider.

(c) Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. Interest owed of less than $2 on a single claim does not have to be paid by the licensed insurer or managed care plan. Interest can be paid on the same check as the claim payment or on a separate check. If the licensed insurer or managed care plan combines interest pay-

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ments for more than one late clean claim, the check shall include information listing each claim covered by the check and the specific amount of interest being paid for each claim.

(d) Claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the readjudication is provided to the plan. Additional moneys which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. The prompt payment requirement of the act also applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation for the entire claim has been supplied to the licensed insurer or managed care plan, but the licensed insurer or managed care plan has determined that it is not obligated to make payment.

(e) Licensed insurers and managed care plans shall provide written disclosure to health care providers of all the data elements necessary to insure that a claim is without defect or impropriety and meets the definition of clean claim under the act.

(1) Licensed insurers and managed care plans shall provide this information to currently participating health care providers by April 10, 2000. For health care providers entering into a participation agreement with the licensed insurer or managed care plan after March 11, 2000, the licensed insurer or managed care plan shall provide this information within 30 days of the parties entering into a participation agreement. If changes are made to the required data elements, this information shall be provided to participating health care providers at least 30 days before the effective date of the changes.

(2) For nonparticipating health care providers, a licensed insurer or managed care plan shall provide this information within 45 days of an oral or written request from the health care provider.

(f) Prior to filing a complaint with the Department, health care providers who believe that a licensed insurer or managed care plan has not paid a clean claim in accordance with the act and this chapter shall first contact the licensed insurer or managed care plan to determine the status of the claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered by the licensed insurer or the managed care plan to be a clean claim. Licensed insurers and managed care plans shall respond to the health care provider's inquiries regarding the status of unpaid claims within 45 days of submission of the claim or within 30 days of the inquiry, if the inquiry is made after the 45-day period.

(g) Health care providers may file a complaint, either individually or in batches, with the Department prior to receipt of a determination from a licensed

insurer or managed care plan as to whether a claim is considered a clean claim if one of the following applies:

(1) The licensed insurer or managed care plan has not responded to a health care provider's inquiries regarding the status of an unpaid claim within 45 days of submission of the claim or within 30 days of the inquiry, if the inquiry is made after the 45-day period.

(2) The health care provider believes that the licensed insurer or managed care plan is otherwise not complying with the prompt payment provisions of the act.

(h) Complaints to the Department regarding the prompt payment of claims by a licensed insurer or managed care plan under the act and this chapter shall contain the following information:

(1) The provider's name, identification number, address and daytime telephone number and the claim number.

(2) The name and address of the licensed insurer or managed care plan.

(3) The name of the patient and employer (if known).

(4) The dates of service and the dates the claims were submitted to the licensed insurer or managed care plan.

(5) Relevant correspondence between the provider and the licensed insurer or managed care plan, including requests for additional information from the licensed insurer or managed care plan.

(6) Additional information which the provider believes would be of assistance in the Department's review.

(7) Any additional information pertinent to the complaint as requested by the Commissioner.

(i) This chapter does not prevent the Department from investigating a complaint when the health care provider has failed to contact the licensed insurer or managed care plan as provided for in subsection (f).

**Notes of Decisions**

*Private Action*

Because there is no indication in the regulations that a private right of action exists, and because those same regulations provided a system of enforcement by the Insurance Department, the court held that there is not private cause of action for violation of the prompt payment provisions of the Health Care Act (40 P. S. § 991.2101 et seq.) *Solomon v. United States Healthcare Systems of Pennsylvania*, 797 A.2d 346 (Pa. Super. 2002); appeal denied 808 A.2d 573 (Pa. 2002).

**Cross References**

This section cited in 28 Pa. Code § 9.722 (relating to plan and health care provider contracts).

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