

**REPORT OF  
MARKET CONDUCT EXAMINATION  
OF**

**GEISINGER HEALTH PLAN  
Danville, Pennsylvania**

**AS OF  
May 27, 2009**

**COMMONWEALTH OF PENNSYLVANIA**



**INSURANCE DEPARTMENT  
BUREAU OF MARKET CONDUCT**

**Issued: July 22, 2009**

# GEISINGER HEALTH PLAN

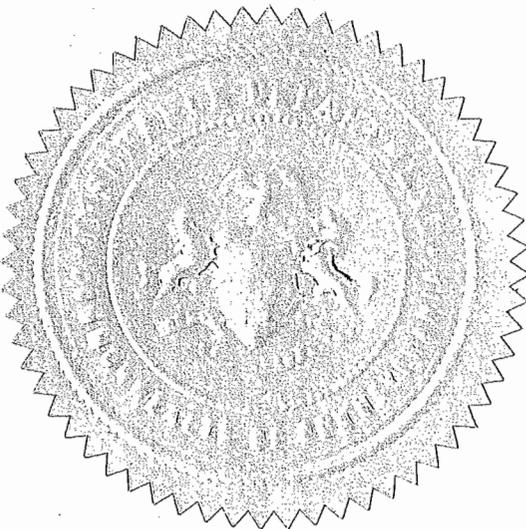
## TABLE OF CONTENTS

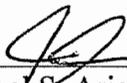
<b>Order</b>	
<b>I.</b>	<b>Introduction</b> 2
<b>II.</b>	<b>Scope of Examination</b> 5
<b>III.</b>	<b>Company History and Licensing</b> 6
<b>IV.</b>	<b>Forms</b> 8
<b>V.</b>	<b>Claims</b> 9
	<b>A. CBH Alcohol and Drug Claims Denied</b> 10
	<b>B. UBH Alcohol and Drug Claims Denied</b> 11
	<b>C. CBH Mental Illness Claims Denied</b> 13
	<b>D. UBH Mental Illness Claims Denied</b> 14
	<b>E. CBH Alcohol and Drug Services Denied</b> 15
	<b>F. UBH Alcohol and Drug Services Denied</b> 17
<b>VI.</b>	<b>Recommendations</b> 18
<b>VII.</b>	<b>Company Response</b> 19

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22<sup>ND</sup> day of July, 2008, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



  
\_\_\_\_\_  
Joel S. Ario  
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
GEISINGER HEALTH PLAN	:	Section 2166(A) and (B) of the Act of
100 North Academy Avenue	:	June 17, 1998, P.L. 464, No. 68 (40 P.S.
Danville, PA 17822	:	§§991.2166)
	:	
	:	Section 5(b)(c) of the Insurance
	:	Company Law, No. 150 (40 P.S. §764g)
	:	
	:	Section 602-A of the Insurance
	:	Company Law, Act of May 17, 1921,
	:	P.L. 682, No. 284 (40 P.S. § 908-2)
	:	
	:	Title 31, Pennsylvania Code, Sections
	:	89.612 and 154.18
	:	
Respondent.	:	Docket No. MC09-07-005

CONSENT ORDER

AND NOW, this *22nd* day of *July*, 2009, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

### FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is Geisinger Health Plan, and maintains its address at 100 North Academy Avenue, Danville, Pennsylvania 17822.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 through December 31, 2006.
- (c) On May 27, 2009 the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on June 26, 2009.
- (e) After consideration of the June 26, 2009 response, the Insurance Department has modified the Examination Report as attached.

(f) The Examination Report notes violations of the following:

(i) Section 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S.

§ 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;

(ii) Section 5(b)(c) of the Insurance Company Law, No. 150 (40 P.S. §764g),

which provides: (b) Any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employees: Provided that this section shall not include accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS supplement, long-term care, disability income, workers' compensation or automobile medical payment;

(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:

(1) coverage for serious mental illnesses shall include at least thirty (30)

inpatient and sixty (60) outpatient days annually; (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient

days on a one-for-two basis; (3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses; (4) cost-sharing arrangements, including, but not limited to, deductibles and co-payments for coverage of serious mental illnesses shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection;

(iii) Section 602-A of the Insurance Company Law (40 P.S. § 908-2), which states all group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act shall, in addition to other provisions required by this act, include within the coverage, those benefits for alcohol or other drug abuse and dependency as provided;

(iv) Title 31, Pennsylvania Code, Section 89.612, which states (a) non-hospital, residential alcohol treatment services which are included as a covered benefit shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services; (b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services; (c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up

to 15 non-hospital, residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b); and (d) Treatment services provided in subsections (a) through (c) may be subject to a lifetime limit, for a covered individual, of 90 days of no-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits; and

- (v) Title 31, Pennsylvania Code, Section 154.18(c), which states 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.

#### CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent's violations of Sections 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182),

which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.

(c) Section 5(b)(c) of the Insurance Company Law, Serious Mental Illness Coverage (40 P.S. § 764g), which requires (c) health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:

(1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;

(2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

(3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses.

(d) Respondent's violations of Title 31, Pennsylvania Code, Section 89.612 are punishable under Section 354 of the Insurance Company Law (40 P.S. § 477b) by suspension or revocation of the license(s) of Respondent; refusal, for a period not to exceed one year thereafter, to issue a new license to Respondent; or imposition of a fine of not more than one \$1,000.00 for each act in violation of the Act.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Ten Thousand Dollars (\$10,000.00) to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report.
- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

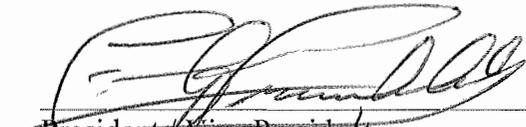
8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

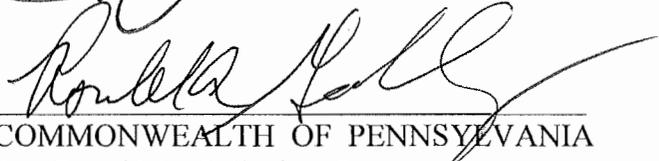
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: GEISINGER HEALTH PLAN, Respondent

  
\_\_\_\_\_  
President / Vice President

  
\_\_\_\_\_  
Secretary / Treasurer

  
\_\_\_\_\_  
COMMONWEALTH OF PENNSYLVANIA  
By: Ronald A. Gallagher, Jr.  
Deputy Insurance Commissioner

## **I. INTRODUCTION**

The Market Conduct Examination was conducted on Geisinger Health Plan (GHP); hereafter referred to as “Company,” at the Company’s office located in Danville, Pennsylvania, September 1, 2008, through October 3, 2008. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Daniel Stemcosky, AIE, FLMI  
Market Conduct Division Chief

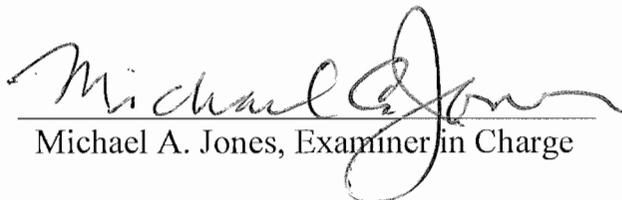
Michael A. Jones  
Market Conduct Examiner

Michael T. Vogel, MCM  
Market Conduct Examiner

Gerald P. O'Hara, Jr.  
Market Conduct Examiner

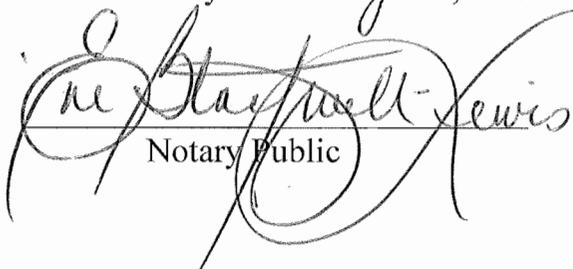
**Verification**

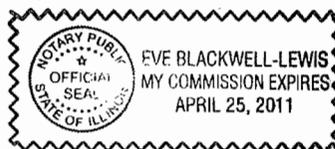
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

  
Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 26<sup>th</sup> Day of May, 2009

  
Notary Public



## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2005, through December 31, 2006, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Forms and Procedures and Claim Handling Practices and Procedures related to alcohol and substance abuse and mental illness coverage.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

### **III. COMPANY HISTORY AND LICENSING**

The Pennsylvania HMO Law was enacted in 1972. In 1973, the Federal Government enacted the HMO Act, part of which required employers with 25 or more employees to offer a federally qualified HMO as an alternative to their traditional health care benefit plans.

Between 1972 and 1984, the Company was a pilot, rural, prepaid health plan offered to Geisinger Medical Center employees and approximately 1,500 residents in a five-county area (Columbia, Montour, Northumberland, Snyder and Union) surrounding the Geisinger Medical Center, which is located in Danville, Pennsylvania.

The Company was incorporated on August 20, 1984, licensed by the Department on February 15, 1985, and commenced business on March 1, 1985, writing health coverage in a 15-county area surrounding Geisinger Medical Center. In February 1987, it became federally qualified for a 17-county service area in central and northeastern Pennsylvania. On June 1, 1996, the service area was expanded by an additional six counties. This qualification ended on January 1, 2000.

In February 1994, the Company became qualified to issue Medicare risk-based contracts under Section 1876 of the Social Security Act and federal regulations under 42 CFR 417.400, Subpart C. Enrollment in the Company's Medicare Advantage program began April 1, 1994.

On July 1, 1997, Geisinger Health System Foundation merged with Penn State Hershey Medical Center to form the Penn State Geisinger Health Plan. On June 30, 2000, the unwinding of the affiliation between Geisinger Health System Foundation and The Pennsylvania State University was completed.

Geisinger Health Plan's total Pennsylvania earned premium, as reported in their 2008 annual statement was \$788,462,485. The total annual member months was reported as 1,671,167.

#### **IV. FORMS**

The Company was requested to provide a list and copies of all individual and group policy/certificate forms and conversion contracts used during the experience period of in Pennsylvania. The forms provided were reviewed to ensure compliance with pertinent state insurance laws and regulations including, but not limited to: Insurance Company Law, Section 354; Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Warning Notice; the Accident and Health Reform Filing Act, No. 159 (40 P.S. §3803); and the Quality Health Care Accountability and Protection Act No. 68, Section 2136 (40 P.S. §991.2136), Required Disclosure.

No violations were noted.

## V. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing alcohol and substance abuse and mental illness claims during the experience period. The Company advised that two third party administrators were utilized to administrate their claims for alcohol and drug and mental illness during the experience period. The two vendors were United Behavioral Health (UBH) and Cigna Behavioral Health (CBH). The Company provided the following procedural guidelines and manuals:

1. United Behavioral Health (UBH) Delegation Agreement
2. United Behavioral Health (UBH) Administrative Service Agreement
3. Mental Health and Substance Abuse Reinsurance Agreement
4. Cigna Behavioral Health (CBH) Market Conduct Examination of GHP (2008) Data (CD)

The CD, claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The claim file review consisted of 6 areas:

- A. CBH Alcohol and Drug Claims Denied
- B. UBH Alcohol and Drug Claims Denied
- C. CBH Mental Illness Claims Denied
- D. UBH Mental Illness Claims Denied
- E. CBH Alcohol and Drug Services Denied
- F. UBH Alcohol and Drug Services Denied

All claim files were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171); Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options; Title 31, Pennsylvania Code, Section 89.612, Minimum covered services; Section 5 of the Insurance Company Law, No. 150 (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

### **A. CBH Alcohol and Drug Claims Denied**

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2005 to June 30, 2006. The Company identified a universe of 1,311 denied alcohol and drug claims administered by Cigna Behavioral Health (CBH). From the original universe, the Department utilized an audit program and extracted the following denial reasons: Exceeded yearly benefits, no approval or authorization and services not medically necessary. As a result of the extraction, the new universe was 529 denied claims. From the new universe, a random sample of 50 claim files was requested, received and reviewed.

The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

#### **1 Violation – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A)**

*A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.*

The clean claim noted was not paid within 45 days of receipt.

### **1 Violation – Title 31, Pennsylvania Code, Section 154.18(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 payment on the claim noted was not paid within 30 days of the claim payment.

### **B. UBH Alcohol and Drug Claims Denied**

The Company was requested to provide a list of all claims denied during the experience period of July 1, 2006 to December 31, 2006. The Company identified a universe of 1,890 denied alcohol and drug claims administered by United Behavioral Health (UBH). From the original universe, the Department utilized an audit program and extracted the following denial reasons: Charges sent for medical review, Network provider required, Notification required and Units greater than usual for review send notes. As a result of the extraction, the new universe was 262 denied claims. From the new universe, a random sample of 40 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following concern and violations were noted:

**Concern:** As a result of the Company's response and clarification of their claim handling procedures, the violations of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania Code, Section 89.612 along with the corresponding violations to Section 5 of the Unfair Insurance Practices Act, have been removed. The Department is however, concerned that the Company does not

document in the claim file any disclosure or request to the provider of the Company's requirements for a written certification to invoke Alcohol and Substance Abuse mandated benefits.

**1 Violation – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A)**

*A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.*

The clean claim noted was not paid within 45 days of receipt.

**1 Violation – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims (B)**

*If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two (\$2) dollars.*

The correct amount of interest due on the listed claim was not paid as required.

**1 Violation – Title 31, Pennsylvania Code, Section 154.18(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 payment on the claim noted was not paid within 30 days of the claim payment.

### **C. CBH Mental Illness Claims Denied**

The Company was requested to provide a list of denied claims finalized during the experience period of January 1, 2006 to December 31, 2006. The Company identified a universe of 5,465 denied mental illness claims administered by Cigna Behavioral Health (CBH). A random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent insurance state laws and regulations. The following violations were noted:

#### **1 Violation - Insurance Company Law, No. 150, Section 5(b)(c)**

##### **(40 P.S. §764g) Coverage for Serious Mental Illnesses**

*(b) This section shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employees: Provided that this section shall not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS (Civilian Health and Medical Program for the Uniform Services) supplement, long-term care, disability income, workers' compensation or automobile medical payment.*

*(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:*

*(1) Coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;*

*(2) A person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;*

*(3) There shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;*

*(4) Cost-sharing arrangements, including, but not limited to, deductibles and co-payments for coverage of serious mental illnesses shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection.*

The claim noted was denied inappropriately as reaching the yearly maximum of 30 days. The service has a 60 day yearly maximum.

#### **D. UBH Mental Illness Claims Denied**

The Company was requested to provide a list of denied claims finalized during the experience period of January 1, 2006 to December 31, 2006. The Company identified a universe of 6,173 denied mental illness claims administered by United Behavioral Health (UBH). A random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent insurance state laws and regulations. The following violations were noted:

#### **5 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (A)**

*A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 50 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company.*

The 5 clean claims noted were not paid within the required 45 days of receipt.

**4 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166),  
Prompt Payment of Provider Claims (B)**

*If a licensed insurer or a Managed Care Plan Fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two (\$2) dollars.*

The interest on the 4 clean claims noted was not paid as required.

**4 Violations – Title 31, Pennsylvania Code, Section 154.18(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 payments for 4 claims noted were not paid within 30 days of the claim payment.

**E. CBH Alcohol and Drug Services Denied**

The Company was requested to provide a list of alcohol and drug rehabilitative services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 29 denied alcohol and drug rehabilitative services administered by Cigna Behavioral Health (CBH). All 29 denied services files were requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy

contract, as well as complying with pertinent insurance state laws and regulations. The following violations were noted:

**8 Violations - Insurance Company Law, Section 602-A (40 P.S. §908-2)**

**Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.**

*(a) All group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act" or the act of July 29, 1977 (P. L. 105, No. 38), known as the " Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 603-A, 604-A, and 605-A.*

**And**

**Title 31, Pennsylvania Code, Section 89.612 Minimum covered services.**

*(a) Non-hospital, residential alcohol treatment services which are included as a covered benefit under Article VI-A of the act (40 P. S. § § 908-1—908-8) shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.*

*(b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services.*

*(c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital residential alcohol*

*treatment days, shall be available in addition to the minimum required in subsections (a) and (b).*

*(d) Treatment services provided in subsections (a) (c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.*

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa. B. 4041, dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. However, the location of treatment is subject to the insuring entity's requirements regarding the use of participating providers.

The denial of coverage for the 8 service requests noted is not in compliance with the requirement for alcohol and substance abuse mandated benefits.

#### **F. UBH Alcohol and Drug Services Denied**

The Company was requested to provide a list of alcohol and drug rehabilitative services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 12 denied alcohol and drug rehabilitative services administered by United Behavioral Health (UBH). All 12 denied services files were requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent insurance state laws and regulations. No violations were noted.

## **VII. RECOMMENDATIONS**

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise internal control procedures to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. §908-2) and Title 31, Pennsylvania Code, Chapter 89, Section 89.612 Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.
2. The Company must review and revise internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. §764g)
3. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.
4. The Company must review internal control procedures to ensure the timely payment of interest as required by Section 2166(B) of the Insurance Company Law of 1921 (40 P.S. §991.2166) and Title 31, Pennsylvania Code, Section 154.18. Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.
5. The Company must provide to the Insurance Department within 60 days of the Report issue date, verification of claim payment and interest on the claims noted in the examination that were denied inappropriately.

## **VIII. COMPANY RESPONSE**



**FEDEX OVERNIGHT DELIVERY**

June 25, 2009

Mr. Daniel A. Stemcosky, AIE, FLMI  
Market Conduct Division Chief  
Commonwealth of Pennsylvania  
Insurance Department  
Bureau of Enforcement  
Market Conduct Division  
1321 Strawberry Square  
Harrisburg, PA 17120

Re: Examination Warrant Number: 007-M26-054  
Geisinger Health Plan Market Conduct Examination

Dear Mr. Stemcosky:

Geisinger Health Plan (GHP) has received the Pennsylvania Insurance Department's Report of Examination dated May 27, 2009 and is submitting the following information in response to the recommendations and findings contained within that report. The attached document addresses each recommendation included in the report.

In recognition of all of the time and effort put into completing this examination and publishing this report, GHP would like to thank the Department and its auditors for sharing their observations and allowing us the opportunity to respond. GHP takes any and all communications from the Department very seriously and believes that it has appropriately resolved the issues raised by the examination.

Furthermore, GHP is committed to complying with all laws and regulations and structures its practices to reflect this intention. The report issued by the Department identified instances where the auditors determined our practices did not meet these requirements. For some of these findings, we have outlined in the attached response why we consider our established practices were in conformity with the laws and regulations. We respectfully submit these explanations to the Department for consideration.

We welcome the opportunity to discuss any of these issues further.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Weader", with a long horizontal flourish extending to the right.

David J. Weader  
Vice President, Legal Services

Enclosures

Geisinger Health Plan  
Legal Services, M.C. 32-20  
100 North Academy Avenue  
Danville, Pennsylvania 17822  
Phone: (570) 271-7389  
Fax: (570) 214-5305

## VIII. COMPANY RESPONSE

- 1. The Company must review and revise internal control procedures to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. § 908-2) and Title 31, Pennsylvania Code, Chapter 89, Section 89.612 Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.**

**Response:**

During the experience period, the Company contracted with two different behavioral health administrators. United Behavioral Health (UBH) has administered behavioral health benefits for GHP since July 1, 2006 and continues to administer the benefits currently. Cigna Behavioral Health (CBH) administered behavioral health benefits for the Company until July 1, 2006.

Regarding the violations identified from the UBH experience period, UBH has reviewed its internal control procedures and will continue to monitor and enhance control procedures on an ongoing basis to ensure compliance with the noted regulations. However, the Company respectfully maintains the position that the 10 claims noted as violations under this section of the report were denied correctly. Since claims payment is directly tied to whether or not an authorization was put in place for the services, it is important to walk through the UBH utilization management process in an effort to explain how UBH made the underlying decisions that the services were not authorized. Because the services in these 10 claims were not authorized for payment, the Company believes that the claims denials were appropriate.

UBH has in place a Pennsylvania approved written policy and procedure titled *Compliance with PA Act 106* that all UBH staff follow in order to operationalize Act 106 (“the Act”) in a manner consistent with the requirements the state has mandated. This policy and procedure was previously reviewed and approved by the Pennsylvania Department of Health and is attached as Appendix A to this document. The Company believes UBH acted in accordance with the policy noted above, the Act and the Department Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003) (“PID Notice”). Furthermore, UBH followed the Pennsylvania approved policy and procedure currently in place for management of cases that potentially fall under the umbrella of the Act. By citing the legislation, portions of the PID Notice and the language from the UBH policy and procedure, the Company intends to clarify the legal and operational basis for the actions taken, which the Company maintains are in compliance with the Act and in accordance with UBH’s internal policy and procedure which serves to operationalize the Act.

The summary page of the policy and procedure entitled *Compliance with PA Act 106*, provides as follows:

The only requirement before an insured person obtains non-hospital residential, inpatient (hospital or non-hospital facility with a written affiliation agreement with a hospital) detox, and outpatient coverage is a certification from a licensed physician or licensed psychologist (that the member does have a substance abuse or dependency diagnosis, and does need the “prescribed” treatment) and referral from a licensed physician or licensed psychologist.

UBH has consistently interpreted this to mean that a physician or psychologist needs to provide a **written** prescription for the type and duration of treatment that is requested for the member. As per the Pennsylvania Department of Health approved UBH policy and procedure *Compliance with PA Act 106*:

A. When a Pennsylvania Drug and Alcohol program representative invokes PA Act 106, the following procedures are to be adhered to by Care Advocacy personnel:

1. A written physician’s order is to be requested from the facility/program via facsimile prior to the end of the business day, to verify the specific request for coverage of services, as well as to verify the parameters of applicability noted in Section C.1-4 in the “Standards and Applicability” section above.

2. The Care Advocate is to document the specific request (including dates of service as well as level of care requested) into the member’s electronic record and place an “Alert” note in the member record if the record is in LINX. The “Alert” note should state the following:

- a. That a PA Act 106 written physician’s order has been received.
- b. The date of receipt.
- c. The number of days prescribed.

3. The Care Advocate is to provide a copy of the written physician’s order to the Clinical Program Manager for tracking.

4. This written physician’s order is to be forwarded to the appropriate department for scanning.

Additionally, the PID Notice states the following:

Act 68 of 1998 (40 P. S. §§ 991.2101--991.2193), governing quality health care accountability and protection, does not change the requirements under the act and should be read in conjunction with these existing requirements. Thus, an entity subject to Act 68 may utilize precertification or utilization reviews, provided, however, that the decision of the precertification or utilization review does not limit the act certification and referral by the licensed physician or licensed psychologist.

Accordingly, the Company maintains that UBH's contractual requirements for prior notification (preauthorization) of treatment for our members, as well as utilization review, are allowed in these cases. The use of the prior notification (preauthorization) terminology is a member benefit and provider contractual obligation which requires that UBH be notified prior to treatment delivery (i.e., that the care be preauthorized) and is distinguished from a written certification for treatment under the Act. Moreover, the contractual obligation requiring notification in advance of treatment is wholly consistent with the PID Notice which states that "The only requirement **before** an insured person obtains...coverage... is a certification from a licensed physician or licensed psychologist...and referral from a licensed physician or licensed psychologist." Therefore, in both instances UBH must be notified in advance of the treatment (**before** treatment begins). Stated another way, the Act cannot be invoked if UBH is not aware of the proposed treatment and has not received a certification and referral as required under the Act. It is for these reasons that the Company respectfully asserts that the claims listed as UBH violations under this section were denied correctly.

For the claims falling within the CBH experience period, the Company acknowledges these eight violations. On two occasions, CBH erroneously denied benefit authorization of substance abuse services requested by certified health care professionals. With respect to the remaining violations, CBH erroneously failed to extend the outpatient benefits by an additional 30 visits by administering the 2-to-1 exchange for up to 15 substance abuse residential days. CBH ceased administering the Company's behavioral health benefits effective July 1, 2006. The Company will continue to monitor its internal control procedures to ensure compliance with the noted regulations.

- 2. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. § 1171.5).**

**Response:**

The Company takes seriously its obligations under the Unfair Insurance Practices Act to ensure that none of its business practices constitute unfair claim settlements. The violations noted under this section fell within the UBH

experience period. UBH has reviewed its internal control procedures and will continue to monitor and enhance control procedures on an ongoing basis to ensure compliance with the noted regulations.

While the Company notes the Department's position that the claims were denied incorrectly, the Company respectfully maintains the position that the 10 claims noted as violations under this section were denied correctly. As already outlined in #1 above, the Company believes the claims denials were appropriate because the services were not authorized. Please refer to the UBH explanation contained in #1 for a full explanation.

**3. The Company must review and revise internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. § 764g).**

The Company acknowledges these violations, which occurred during the CBH experience period. With respect to these violations, CBH inadvertently applied only 30 serious mental health outpatient visits per benefit plan year rather than the requisite 60 visit limit. CBH ceased administering the Company's behavioral health benefits effective July 1, 2006. The Company will continue to monitor its internal control procedures to ensure compliance with the noted regulations.

**4. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. § 991.2166), relating to prompt payment of provider claims.**

As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for GHP since July 1, 2006 and continues to administer the benefits currently. CBH administered behavioral health benefits for the Company until July 1, 2006.

Regarding the violations that fell within the UBH experience period, UBH has reviewed its internal control procedures and will continue to monitor and enhance control procedures on an ongoing basis to ensure compliance with the noted regulations. The one violation for interest not paid within 30 days of the claim payment was caused by an error made by a processor which resulted in the claim not being paid when an authorization did exist for the services submitted. The processor no longer works for UBH. However, this claim was discussed with all processors in a team meeting on October 21, 2008. During the meeting the claim was reviewed, the error was identified, the prompt payment requirement was reviewed and education was provided on how to prevent these types of errors from occurring in the future.

Regarding the five violations involving clean claims that were not paid within the 45 days of receipt, the errors occurred due to the system being loaded with incorrect benefits. UBH is working with the area that loads benefits into the system to identify the root cause of the problem and will develop and implement a Corrective Action Plan.

However, the Company maintains the position that the additional 10 claims noted as violations under this section were denied correctly because the services were not authorized for payment. The Company's position was already outlined in #1 above. Please refer to the UBH explanation contained in #1 for a full explanation.

For the violations falling under the CBH claim file review, the Company acknowledges this one violation. CBH initially denied the claim due to provider billing issues including that the claim was missing key information (i.e., full and proper name of the vendor) and the services were submitted on the wrong claim form. Once CBH received the additional information required to process the claim, it authorized services but inadvertently failed to submit the reprocessing request. Upon discovery of this oversight arising from the audit, CBH submitted claims payment to the provider including late payment interest dating back to receipt of the additional requisite claims information. CBH ceased administering the Company's behavioral health benefits effective July 1, 2006. The Company will continue to monitor its internal control procedures to ensure compliance with the noted regulations.

- 5. The Company must review internal control procedures to ensure the timely payment of interest as required by Section 2166(B) of the Insurance Company Law of 1921 (40 P.S. § 991.2166) and Title 31, Pennsylvania Code, Section 154.18. Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.**

As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for GHP since July 1, 2006 and continues to administer the benefits currently. CBH administered behavioral health benefits for the Company until July 1, 2006.

Regarding the violations under this section that fell within the UBH experience period, UBH has reviewed its internal control procedures and will continue to monitor and enhance control procedures on an ongoing basis to ensure compliance with the noted regulations. In previous submissions to the Department, the Company has already provided proof of interest payment on the claims that have been acknowledged as violations.

For the violations falling under CBH's claim file review, the Company acknowledges these violations. CBH initially denied the claim due to provider billing issues including that the claim was missing key information (i.e., full and proper name of the vendor) and the services were submitted on the wrong claim form. Once CBH received the additional information required to process the claim, it authorized services but inadvertently failed to submit the reprocessing request. Upon discovery of this oversight arising from the audit, CBH submitted claims payment to the provider including late payment interest dating back to receipt of the additional requisite claims information. CBH ceased administering the Company's behavioral health benefits effective July 1, 2006.

The Company will provide any proof of interest payment on the claims noted in the examination that has not already been provided to the Department by July 26, 2009.

**6. The Company must provide to the Insurance Department within 60 days of the Report issue date, verification of claim payment and interest on the claims noted in the examination that were denied inappropriately.**

For the violations listed under the UBH experience period, the Company has already provided proof of interest payment on the claims that have been acknowledged as violations. Further, as indicated in #1 and #2, the Company maintains the position that the additional 10 claims noted as violations under this section were denied correctly.

The Company will provide any verification of claims payment and interest on the claims noted in the examination that were deemed to have been denied inappropriately that has not already been provided to the Department by July 26, 2009. Furthermore, the Company will cure any outstanding violation and provide proof of claim and interest payment, upon the direction of the Department after review of this response

# UNITED BEHAVIORAL HEALTH

## CARE ADVOCACY POLICIES AND PROCEDURES

### State Specific P&P - Pennsylvania

#### **Title: Compliance with PA Act 106**

*Section: Care Advocacy Process*

*Effective Date: February 2006*

*Revision Date: December 2007*

*Last Review Date: December 2007*

*Approved By:*



#### **PURPOSE:**

To ensure that UBH members who fall under the jurisdiction of PA Act 106 can exercise the rights to which they are entitled under this act. Further, the intent of this policy is to summarize the requirements of PA Act 106 and the procedures to be followed.

#### **POLICY:**

UBH recognizes the right of members who meet the criteria of PA Act 106 to be duly covered by this act. PA Act 106 specifies that all group policies, contracts and certificates subject to PA Act 106 providing hospital or medical/surgical coverage shall include within that coverage certain benefits for alcohol or other drug abuse and dependency. Under PA Act 106, the only lawful prerequisite before an insured obtains non-hospital residential and outpatient, and detoxification coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. UBH may not deny coverage on the basis of medical necessity. The location of treatment is subject to the insuring entity's requirements regarding the use of participating providers.

#### **STANDARDS AND APPLICABILITY:**

- A. Parameters of Applicability of PA Act 106 (see Appendix I for an applicability checklist/training document)
  1. This policy applies to members who are covered by fully insured and HMO plans managed by UBH.
  2. The member must have a policy situated in the Commonwealth of Pennsylvania.
  3. The program/facility must be licensed as a Pennsylvania Substance Abuse program by the Pennsylvania Department of Health for the following levels of care:
    - a. Outpatient/partial hospitalization.

- b. Non-hospital-based residential.
  - c. Detoxification
4. A licensed physician or licensed psychologist has certified that the member has a substance abuse diagnosis.
- B. For admission and discharge/termination practices and determinations, UBH will:
1. Base UM determinations only on the appropriateness of care and services and benefit coverage.
  2. Not specifically reward practitioners or other individuals for issuing adverse determinations of coverage or service care.
  3. Not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.
- C. UBH is compliant with the standards and regulations set forth by JCAHO, NCQA, URAC, HIPAA, ERISA and Pennsylvania state law. These standards and regulations serve as guidelines to ensure that:
1. Care Advocacy decisions are made within the defined timelines.
  2. Appropriately qualified behavioral health care professionals are involved in decision-making.
  3. Relevant clinical information is consistently gathered.
  4. Members are informed of the clinical rationale for adverse determinations.
  5. Members are informed of the right to internal and external appeals.
  6. Members are informed of the right to access relevant portions of their medical records.
  7. Members are informed of the right to file suit under ERISA when applicable.
  8. Member confidentiality is maintained.

**DEFINITIONS:**

- **Alcohol or drug abuse:** Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.
- **Detoxification:** The process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the Pennsylvania Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.
- **Hospital:** A facility licensed as a hospital by the Pennsylvania Department of Health, the Pennsylvania Department of Public Welfare, or operated by the Commonwealth of Pennsylvania and conducting an alcoholism or drug addiction treatment program licensed by the Pennsylvania Department of Health.

- **Inpatient care:** The provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a hospital or non-hospital facility, according to individualized treatment plans.
- **Non-hospital facility:** A facility, licensed by the Pennsylvania Department of Health, for the care or treatment of alcohol-dependent or other drug-dependent persons, except for transitional living facilities.
- **Non-hospital residential care:** The provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol or other drug abuse or dependency in a residential environment, according to individualized treatment plans.
- **Outpatient care:** The provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.
- **Partial hospitalization:** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as an alcoholism or drug addiction treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive care than are offered in outpatient treatment but who does not require inpatient care.

#### **PROCEDURES:**

- A. When a Pennsylvania Drug and Alcohol program representative invokes PA Act 106, the following procedures are to be adhered to by Care Advocacy personnel:
  1. A written physician's order is to be requested from the facility/program via facsimile prior to the end of the business day, to verify the specific request for coverage of services, as well as to verify the parameters of applicability noted in Section C.1-4 in the "Standards and Applicability" section above.
  2. The Care Advocate is to document the specific request (including dates of service as well as level of care requested) into the member's electronic record and place an "Alert" note in the member record if the record is in LINX. The "Alert" note should state the following:
    - a. That a PA Act 106 written physician's order has been received.
    - b. The date of receipt.
    - c. The number of days prescribed.
  3. The Care Advocate is to provide a copy of the written physician's order to the Clinical Program Manager for tracking.
  4. This written physician's order is to be forwarded to the appropriate department for scanning.
  5. If the member's condition and treatment meet UBH Level of Care Guidelines according to the Care Advocate who is reviewing the case, the Care Advocate is to continue to review the case as usual.

6. In the event that the member's condition and treatment do not appear to meet UBH Level of Care Guidelines according to the Care Advocate who is reviewing the case, and if it is a pre-service or concurrent review, a clinical discussion between a UBH Medical Director/Associate Medical Director and the facility MD who wrote the physician's order is to be offered so that a discussion about the clinical rationale for the physician's order can take place.
  7. The Care Advocate is to maintain the process of conducting regular reviews to assess whether the member continues to meet UBH Level of Care Guidelines for tracking and trending purposes.
  8. In the event that it appears to the Care Advocate, Clinical Program Manager, and/or the Medical Director/Associate Medical Director involved, that the facility is keeping the member beyond what is believed by UBH to be an appropriate amount of time, based on the UBH Level of Care guidelines, the case is to be escalated to the appropriate Clinical Operations Director, the Regional Medical Director and the Regional Vice President. The Care Advocate is to continue to authorize the time period required in treatment as per the mandates of PA Act 106.
- B. The mandated benefits under PA Act 106 are as follows:
1. Up to seven (7) days of inpatient detoxification per year, twenty-eight (28) days per lifetime.
    - a. Inpatient detoxification as a covered benefit shall be provided in a hospital or an inpatient non-hospital facility which has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological support services, which meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Pennsylvania Department of Health and is licensed as an alcoholism and/or drug addiction treatment program.
  2. Minimum of thirty (30) days of non-hospital rehabilitation per year, ninety (90) days per lifetime.
    - a. Non-hospital Residential alcohol or other drug services shall be provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Pennsylvania Office of Drug and Alcohol Programs and is appropriately licensed by the Pennsylvania Department of Health as an alcoholism or drug addiction treatment program.
  3. Minimum of thirty (30) units of outpatient/partial hospitalization per year, 120 units per lifetime.
    - a. These services shall be provided in a facility appropriately licensed by the Pennsylvania Department of Health as an alcoholism or drug addiction treatment program.
- C. The above processes and minimum mandated benefit coverage parameters are to be followed in the case of a pre-service or a concurrent review.

- D. In the event that a facility sends a written physician's order to the Care Advocacy Center, referring a covered member to a service that is not mandated by the Commonwealth of Pennsylvania as a benefit to be covered under PA Act 106 (refer to the Standards and Applicability section of this policy, section A. 1-4), or if the member has exhausted his or her above minimum mandated benefits, or if it is a post-service request, this is to be documented in the member's electronic record and brought to the attention of a Clinical Program Manager. The Care Advocate is to follow the regular protocol for conducting reviews as per the UBH policy entitled, "*Utilization Management*".

**Appendix I**  
**Compliance FAQ - PA Act 106**

**What is PA Act 106?**

PA Act 106 is a mandated benefit act involving members with substance abuse problems in facilities licensed by the PA DOH as alcohol or other drug facilities. Fully insured, PA-sitused plans must provide treatment services as per the mandates below. The only requirement before an insured person obtains non-hospital residential, inpatient (hospital or non-hospital facility with a written affiliation agreement with a hospital) detox, and outpatient coverage is a certification from a licensed physician or licensed psychologist (that the member does have a substance abuse or dependency diagnosis, and does need the “prescribed” treatment) and referral from a licensed physician or licensed psychologist. One important aspect of this notice is that it clarifies that the HMO/MCO (Managed Care Organization) cannot override the certifying and referring physician’s order for the type and/or duration of treatment. The only area that the HMO/MCO can change is the location of the treatment.

**The mandated benefits are:**

- Up to 7 days of detoxification per year, 28 days per lifetime.
- Minimum of 30 days rehabilitation per year, 90 days per life time.
- Minimum of 30 units of outpatient/partial hospitalization per year, 120 units per lifetime.

The following PA Act 106 Checklist for Applicability is to be used to assess whether PA Act 106 is applicable.

**ALL OF THE FOLLOWING MUST BE FULFILLED:**

<b>REQUIREMENTS for ACT 106 to APPLY</b>	<b>Yes</b>	<b>No</b>
Is the <b>plan sitused in PA?</b>	<b>X</b>	
Is the plan a <b>Fully Insured or HMO plan?</b>	<b>X</b>	
Has a <b>licensed physician or licensed psychologist certified</b> that the member has a <b>substance abuse or dependency diagnosis and referred</b> the member for treatment to any of the mandated levels of care?	<b>X</b>	
Is the level of care requested any of the mandated levels of care: <b>outpatient, non-hospital residential, or inpatient (hospital or non-hospital facility with a written affiliation agreement with a hospital) detox?</b>	<b>X</b>	
Is the facility appropriately licensed by the PA Department of Health as an alcoholism or drug addiction treatment program? <b>*If services are not in PA, Act 106 is inapplicable.</b>	<b>X</b>	