

Prudent Layperson Transparency and Downcoding Protection State Model Legislation

Be it enacted by the People of the State/Commonwealth of _____

An Act to Protect Emergency Patients using the Prudent Layperson Standard

Section 1: Purpose. The Legislature hereby finds and declares that:

1. Emergency medical care is an essential health benefit.
2. Patients should have access to emergency care based upon a prudent layperson's perception of an emergency medical condition.

Section 2: Definitions:

1. **Emergency Medical Condition.** The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.
2. **Emergency service.** "Emergency service" means a health care service furnished to evaluate, treat, and/or stabilize the emergency medical condition in an emergency facility or setting.
3. **Health Plan:** shall include, but not be limited to: corporations, associations, partnerships, a society or order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of health insurance business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships and corporations including but not limited to: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), contracting medical providers, Third Party Administrators (TPA) worker's compensation carriers, or auto liability carriers and travel insurance carriers providing healthcare benefits to its insureds.
4. **Utilization Review:** claim review for the purpose of determining whether an emergency medical condition existed. Additionally, the term applies to a determination as to whether the complexity of medical decision making justifies the claim and/or Current Procedural Terminology (CPT) codes assigned for the evaluation and/or management of the emergency medical condition.
5. **Independent Emergency Physician Review:** a utilization review conducted by a physician with an unrestricted license in the State/Commonwealth who is board certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine and is not directly or indirectly hired (currently or within the last 2 years) by the health plan except for the purpose of utilization review. The physician shall have substantial professional experience providing emergency medical services within the

last two (2) years in an acute care hospital emergency department. Utilization review shall include a review of the medical record, including but not limited to, the patient's presenting complaint/symptoms, medical history, physical exam, diagnostic testing, treatment, and the medical decision making of the physician. The process of providing utilization review shall be considered the practice of medicine and reviewers are subject to the oversight and review of the medical board of the jurisdiction in which they provide the review.

Section 3: Utilization Review.

All utilization review shall comply with all the items in this section:

1. For emergency services, a health plan shall provide benefits for emergency services without prior authorization.
2. Any coverage denial or modification of a claim for payment must be explained in writing to the beneficiary and clinician, including the reasoning.
3. Whenever a health plan denies coverage or modifies a claim for payment, the determination must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional). Reimbursement for emergency services shall not be denied or modified based solely on the final diagnosis or impression.
4. Before a health plan denies benefits or modifies the CPT code(s) on the claim, reduces reimbursement for an emergency service based on a determination that the level of service was not justified by the complexity of medical decision making and therefore reimbursement will be for a lower level of care or as a nonemergency service, the health plan shall obtain an independent emergency physician review meeting the following minimum criteria: review of the enrollee's medical record, including the nature of the presenting problem/symptoms, patient history, exam and medical decision making, related to the emergency service.
5. If a health plan requests records related to a potential denial of or reimbursement modification for an enrollee's benefits when emergency services were furnished to an enrollee, a clinician has a duty to respond to the health plan in a timely manner.
6. If the independent emergency physician reviewer determines that the reimbursement or any part of the claim should be denied or modified, the Independent Emergency Physician Reviewer shall explain in writing the reason for the modification or denial of reimbursement. If the reviewer determines the level of service was not justified by the complexity of medical decision making and therefore reimbursement will be for a lower level of care or as a nonemergency service, the reviewer shall reference the standard of care and/or medical evidence that led to the determination. The written explanation for the reduction or denial and the reviewer's name, date, signature and supporting evidence shall be provided by the health plan in writing to the patient and clinician.
7. All parties must follow current CPT, Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases (ICD) as mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transactions and Code Set Standards (TCS).

Section 4: Prompt Reimbursement

The health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway.

Section 5: Patient Education/Protection:

1. Health plans shall inform their enrollees at the time of enrollment and no less than annually thereafter that emergency care is a covered benefit, provide the patient with the legal definition of an “emergency medical condition” as defined in Section 2.
2. Plans shall clearly educate their members that if the patient believes they may have an emergency medical condition as defined, the health plan will cover the emergency service, even if after the emergency service, no emergency is found. Plans shall inform patients they are not required to self-diagnose nor fear financial repercussions.
3. All messaging including but not limited to: advertisements, web sites, patient advice, patient correspondence, language in the Explanation of Benefits (EOB) shall be consistent with the above educational requirements and may not be false or misleading. Plans may not discourage appropriate use of the emergency department nor undermine the patient protections of the prudent layperson standard as used in the definition of “emergency medical condition.” Notwithstanding, health plans may educate patients as to the appropriate site of service based upon symptoms and availability of alternative sites of care.

Section 6. Penalties

1. Repeated violations of this act shall be considered an unfair and deceptive trade practice under applicable federal or state law.
2. Civil monetary penalties will apply for repeated violations of this act.
3. Repeated violations of this act shall be subject to the penalties, fines, administrative actions and remedies allowable under the health plan licensing act of this state.