SENATE BILL NO. 394

INTRODUCED BY SVRCEK, O'KEEFE, HOFFMAN, BENGTSON, KEATING, WALLIN, JACOBSON, FRANKLIN, B. BROWN, CRIPPEN, RUSSELL, BROOKE, D. BROWN

IN THE SENATE

FEBRUARY 14, 1991

FIRST READING.

ON BUSINESS & INDUSTRY.

- FEBRUARY 23, 1991 COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
- FEBRUARY 25, 1991 PRINTING REPORT.

SECOND READING, DO PASS AS AMENDED.

INTRODUCED AND REFERRED TO COMMITTEE

FEBRUARY 26, 1991 ENGROSSING REPORT.

THIRD READING, PASSED. AYES, 43; NOES, 6.

TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 4, 1991

APRIL 6, 1991

INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.

FIRST READING.

MARCH 21, 1991 COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.

SECOND READING, CONCURRED IN.

ON MOTION, RULES SUSPENDED TO ALLOW TO PLACE ON THIRD READING THIS DAY

THIRD READING, CONCURRED IN. AYES, 95; NOES, 2.

RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 17, 1991

RECEIVED FROM HOUSE.

SECOND READING, AMENDMENTS CONCURRED IN.

THIRD READING, AMENDMENTS

APRIL 18, 1991

APRIL 19, 1991

SENT TO ENROLLING.

CONCURRED IN.

REPORTED CORRECTLY ENROLLED.

LC 0921/01

LC 0921/01

Senite BILL NO. 1394 1 INTRODUCED BY SILLE 2 Wallin Trento 3 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT 4 OF UTILIZATION REVIEWS BY HEALTH INSURERS 5 THIRD-PARTY PAYORS; TO PROHIBIT A PERSON FROM CONDUCTING 6 UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE 7 COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN: TO 8 9 PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF 10 UTILIZATION REVIEWS BY REQUIRING CONCURRENCE OF A PHYSICIAN 11 IN A DETERMINATION RELATING TO THE NECESSITY OR 12 APPROPRIATENESS OF HEALTH CARE SERVICES RENDERED TO A 13 PATIENT; TO PROVIDE A PRESUMPTION OF MEDICAL NECESSITY OF 14 HEALTH CARE SERVICES IF AN INSURED PERSON IS IN NEED OF IMMEDIATE ADMISSION TO A HEALTH CARE FACILITY; TO PROVIDE 15 16 FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM A 17 UTILIZATION REVIEW; TO AUTHORIZE THE COMMISSIONER OF 18 INSURANCE TO ADOPT RULES; AND PROVIDING AN EFFECTIVE DATE." 19

20

STATEMENT OF INTENT

A statement of intent is required for this bill because
[section 8] requires the commissioner of insurance to adopt
rules for the purpose of implementing [sections 1 through
10].

25 It is the intent of the legislature that the



commissioner of insurance adopt rules necessary for the 1 regulation of utilization reviews in this state. Rules 2 adopted by the commissioner may include but are not limited 3 4 to rules providing for: 5 (1) the performance of utilization review activities; (2) procedures for reconsideration or appeal of adverse 6 7 decisions resulting from utilization reviews; 8 (3) information to be included in the utilization 9 review plan required in [section 3]; 10 (4) utilization review criteria, standards, and 11 procedures; and 12 (5) the protection of the confidentiality of medical 13 records used in the course of utilization reviews. 14 Rules adopted by the commissioner of insurance must be consistent with the purposes of this bill as stated in 15 [section 1] and must supplement the provisions of [sections 16 17 1 through 10]. 18 19 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: NEW SECTION. Section 1. Purpose. The legislature finds 20 and declares that it is the purpose of [sections 1 through 21 22 101 to: (1) promote the delivery of quality health care in a 23

24 cost-effective manner;

25

(2) foster greater coordination between health care INTRODUCED BILL

SB 394

LC 0921/01

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1 providers, third-party payors, and others who conduct 2 utilization review activities;

3 (3) ensure access to health care services; and

4 (4) protect patients, employers, and health care 5 providers by ensuring that utilization review activities 6 result in informed decisions on the appropriateness of 7 medical care made by those best qualified to be involved in 8 the utilization review process.

9 <u>NEW SECTION.</u> Section 2. Definitions. As used in
10 [sections 1 through 10] the following definitions apply:

11 (1) "Commissioner" means the commissioner of insurance 12 provided for in 2-15-1903.

(2) "Health care provider" means a person, corporation,
facility, or institution licensed by the state to provide or
otherwise lawfully providing health care services, including
but not limited to:

(a) a physician, health care facility as defined in 17 18 50-5-101, osteopath, dentist, optometrist, nurse, chiropractor, podiatrist, physical therapist, psychologist, 19 20 licensed social worker, speech pathologist, audiologist, 21 certified chemical dependency counselor, or licensed 22 professional counselor:

(b) an officer, employee, or agent of a person
described in subsection (2)(a) acting in the course and
scope of employment; and

(c) an agency related to or supportive of health care services.

3 (3) "Health care services" means the health care and 4 services provided by health care providers, including 5 drugs, medicines, ambulance services, and other therapeutic 6 and rehabilitative services and supplies.

7 (4) "Utilization review" means a system for review of 8 health care services for a patient to determine the 9 necessity or appropriateness of services, whether that 10 review is prospective, concurrent, or retrospective, when 11 the review will be utilized directly or indirectly in order 12 to determine whether the health care services will be paid, 13 covered, or provided.

14 <u>NEW SECTION.</u> Section 3. Utilization review plan. A 15 person may not conduct a utilization review of health care 16 services provided or to be provided to a patient covered 17 under a contract or plan for health care services issued in 18 this state unless that person, at all times, maintains with 19 the commissioner a current utilization review plan that 20 includes:

(1) a description of review criteria, standards, and
procedures to be used in evaluating proposed or delivered
health care services that, to the extent possible, must:

24 (a) be based on nationally recognized criteria, 25 standards, and procedures;

-4-

-3-

LC 0921/01

1 (b) reflect community standards of care;

2 (c) ensure quality of care; and

3 ensure access to needed health care services; (d)

4 (2) the provisions by which patients or providers may 5 seek reconsideration or appeal of adverse decisions by the 6 person conducting the utilization review;

7 (3) the type and qualifications of the personnel either 8 employed or under contract to perform the utilization 9 review:

10 (4) policies and procedures to ensure that a 11 representative of the person conducting the utilization 12 review is reasonably accessible to patients and health care providers at all times; 13

14 (5) policies and procedures to ensure compliance with all applicable state and federal laws to protect the 15 16 confidentiality of individual medical records;

(5) a copy of the materials designed to 17 inform applicable patients and health care providers of the 18 19 requirements of the utilization review plan;

20 (7) a list of the persons or entities for whom the 21 person is performing utilization reviews in this state; and 22 (8) any other information as may be required by the 23 commissioner that is necessary to implement [sections 1

24 through 10).

25 NEW SECTION. Section 4. Conduct of utilization review. 1 A program of utilization review with regard to health care 2 services provided or to be provided in this state must comply with the following: 3

4 (1) A determination adverse to a patient or to an 5 affected health care provider may not be made on a guestion 6 relating to the necessity or appropriateness for a health 7 care service without prior evaluation and concurrence in the 8 adverse determination by a physician.

9 (2) A determination regarding health care services 10 rendered or to be rendered to a patient that may result in a 11 denial of third-party reimbursement or a denial of 12 precertification for the service must include the written 13 evaluation, findings, and concurrence of a physician trained 14 in the relevant specialty or subspecialty to make it a final 15 determination that the health care service rendered or to be 16 rendered was, is, or may be medically inappropriate.

17 (3) A determination that health care services rendered 18 or to be rendered are medically inappropriate may not be made unless the physician performing the utilization review 19 20 has consulted with the patient's attending physician or 21 other health care provider, as the case may be, concerning the necessity or appropriateness of the health care service. 22 23 NEW SECTION. Section 5. Presumption of medical 24 necessity. If a licensed physician certifies in writing to 25

an insurer within 72 hours of an admission that the insured

-5-

-6-

LC 0921/01

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person admitted was in need of immediate care in a health care facility, the certification constitutes a presumption of the medical necessity of the admission. To overcome this presumption, the entity requesting the utilization review or the person conducting the utilization review shall show by clear and convincing evidence that the admitted person was not in need of immediate care in the health care facility.

8 <u>NEW SECTION.</u> Section 6. Appeal and assignment of 9 claim. (1) A patient or provider affected by an adverse 10 decision has 30 days in which to appeal or seek 11 reconsideration of the adverse decision by the person 12 conducting the utilization review.

13 (2) A final decision on appeal or reconsideration must 14 be made within 30 days of receipt of the medical records by 15 the person conducting the utilization review and not less 16 than 60 days following the request for appeal or 17 reconsideration.

18 (3) Notwithstanding any provision to the contrary 19 contained in a contract or plan for health care benefits 20 issued after July 1, 1991, following denial after 21 utilization review and appeal or reconsideration as provided 22 in this section, a claim for health care benefits may be 23 assigned to the health care provider by the covered person. 24 NEW SECTION. Section 7. Persons considered engaged in 25 practice of medicine. A physician who reviews health care services provided or to be provided in this state for
 utilization review purposes is considered to be engaged in
 the practice of medicine under Title 37, chapter 3.

<u>NEW SECTION.</u> Section 8. Commissioner to adopt rules.
The commissioner shall adopt rules for the implementation of
[sections 1 through 10], including but not limited to rules
providing for:

the performance of utilization review activities;

9 (2) procedures for reconsideration or appeal of adverse
 10 decisions resulting from utilization reviews;

11 (3) information to be included in the utilization 12 review plan required in [section 3];

13 (4) utilization review criteria, standards, and14 procedures; and

15 (5) the protection of the confidentiality of medical16 records used in the course of utilization reviews.

17 <u>NEW SECTION.</u> Section 9. Preemption of federal law. If 18 any provision of [sections 1 through 10] is preempted by 19 federal law or regulations as applied to any specific health 20 care service, then the provision of [sections 1 through 10] 21 that is preempted by federal law or regulations does not 22 apply to that health care service but only to the extent of 23 the preemption.

24 <u>NEW SECTION.</u> Section 10. Application of act - 25 exemptions. (1) The provisions of [sections 1 through 10]

-7-

-8-

LC 0921/01

LC 0921/01

apply to a person or entity performing utilization reviews
 who is, or is affiliated with, under contract with, or
 acting on behalf of;

4 (a) a Montana business entity; or

*

5 (b) a third party that provides or administers health 6 care benefits to citizens of this state including:

7 (i) a health insurer, nonprofit health service plan,
8 health service corporation, employees' health and welfare
9 fund, or preferred provider organization authorized to offer
10 health insurance policies or contracts;

11 (ii) a health maintenance organization issued a 12 certificate of authority in accordance with Title 33, 13 chapter 31; or

14 (iii) a state agency.

15 (2) A general in-house utilization review for a health 16 care provider is exempt from the provisions of [sections 1 17 through 10] as long as the review does not result in the 18 approval or denial of payment for health care services for a 19 particular case.

20 <u>NEW SECTION.</u> Section 11. Codification instruction.
21 [Sections 1 through 10] are intended to be codified as an
22 integral part of Title 33, and the provisions of Title 33
23 apply to [sections 1 through 10].

24 <u>NEW SECTION.</u> Section 12. Effective date. [This act] is
25 effective July 1, 1991.

-End--9-

STATE OF MONTANA - FISCAL NOTE Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0394, third reading.

DESCRIPTION OF PROPOSED LEGISLATION:

An act to regulate the conduct of utilization reviews by health insurers and other third-party payors; to prohibit a person from conducting utilization reviews unless the person maintains with the Commissioner of Insurance a utilization review plan; to protect patients and health care providers in the conduct of utilization reviews by requiring concurrence of a physician in a determination relating to the necessity or appropriateness of health care services rendered to a patient; to provide for the appeal of an adverse decision resulting from a utilization review.

ASSUMPTIONS:

- 1. The potential current and long-term fiscal impact of this bill on health insurers and users of health care services is not subject to reasonable estimation.
- 2. The bill, as amended, does not impose substantial additional duties upon the Commissioner of Insurance in the review of utilization plans or the review of claim appeals. Therefore, there is no material fiscal impact on the State Auditor's Office.
- 3. The Department of Social and Rehabilitation Services administers the Medicaid program in Montana and is expected to incur additional expenses for physician consultants and a 0.50 FTE utilization review coordinator as a result of the bill. Increased hourly consultant expenses are estimated at \$75 per hour based upon historical data for physicians and other practitioners who provide utilization review services.
- 4. Funding for the increased expenses is based upon 75% federal funds and 25% general fund for personal services and contract consulting services and 50% federal/50% general fund for equipment.
- 5. There will be no material impact on overall Medicaid benefit payments.

FISCAL IMPACT:

Department of Social and Rehabilitation Services-Medicaid Division

	FY '92			FY '93		
<u>Expenditures:</u>	Current Law	Proposed Law	<u>Difference</u>	Current Law	Proposed Law	Difference
F.T.E.	0.00	0.50	0.50	0,00	0.50	0.50
Personal Services	0	14,886	14,886	0	14,886	14,886
Operating Expenses	0	22,781	22,781	0	30,375	30,375
Equipment	0	4,000	4,000	0	0	0
Total	0	41,667	41,667	0	45,261	45,261
Funding:						
General Fund (01)	0	11,417	11,417	0	11,315	11,315
Federal Funds (03)	<u>0</u>	<u>30,250</u>	<u>30,250</u>	<u>0</u>	33,946	33,946
Total	ō	41,667	41,667	ō	45,261	45,261

General Fund Impact (Decrease)

ROD SUNDSTED, BUDGET DIRECTOR D Office of Budget and Program Planning

(11.41)

Fiscal Note for SB0394, third reading

SVRCEK, PRIMARY SPONSOR

394-1

(11.315)

SB 0394/02 Approved by comm. On Business & Industry

1	SENATE BILL NO. 394
2	INTRODUCED BY SVRCEK, O'KEEFE, HOFFMAN, BENGTSON, KEATING,
3	WALLIN, JACOBSON, FRANKLIN, B. BROWN, CRIPPEN, RUSSELL,
4	BROOKE, D. BROWN

6 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT OF UTILIZATION REVIEWS BY HEALTH INSURERS 7 AND OTHER THIRD-PARTY PAYORS: TO PROHIBIT A PERSON FROM CONDUCTING 8 UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE 9 COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN: TO 10 PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF 11 UTILIZATION REVIEWS BY REQUIRING CONCURRENCE OF A PHYSICIAN 12 13 IN A DETERMINATION RELATING TO THE NECESSITY OR 14 APPROPRIATENESS OF HEALTH CARE SERVICES RENDERED TO A PATIENT: TO-PROVIDE-A-PRESUMPTION-OP--MEDICAL--NBCESSITY--OP 15 16 HEALTH--CARE--SERVICES--IF--AN--INSURED-PERSON-IS-IN-NEED-OF 17 IMMEDIATE-ADMISSION-TO-A-HEADTH-CARE--FACILITY; TO PROVIDE 18 FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM A UTILIZATION REVIEW; AND TO AUTHORIZE THE COMMISSIONER OF 19 INSURANCE TO ADOPT RULES :- AND-PROVIDING-AN-BPPECTIVE-DATE." 20

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STATEMENT OF INTENT

23 A statement of intent is required for this bill because 24 [section θ <u>7</u>] requires <u>AUTHORIZES</u> the commissioner of 25 insurance to adopt rules for the purpose of implementing



1 [sections 1 through ±0 9].
2 It is the intent of the legislature that the

3 commissioner of insurance adopt rules necessary for the 4 regulation of utilization reviews in this state. Rules 5 adopted by the commissioner may include but are not limited 6 to rules providing for:

- 7 (1)--the-performance-of-utilization-review-activities;
- 8 {2}--procedures-for-reconsideration-or-appeal-of-adverse

9 decisions-resulting-from-utilization-reviews;

10 (3)(1) information to be included in the utilization
11 review plan required in [section 3];

12 (4)(2) utilization review criteria, standards, and 13 procedures; and

14 (5)(3) the protection of the confidentiality of medical 15 records used in the course of utilization reviews.

16 Rules adopted by the commissioner of insurance must be 17 consistent with the purposes of this bill as stated in 18 [section 1] and must supplement the provisions of [sections 19 1 through if 9].

20

21 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Purpose. The legislature finds
and declares that it is the purpose of [sections 1 through
if 9] to:

25 (1) promote the delivery of quality health care in a

-2-

1 cost-effective manner;

2 (2) foster greater coordination between health care
3 providers, th rd-party payors, and others who conduct
4 utilization review activities:

5 (3) ensure access to health care services; and

6 (4) protect patients, employers, and health care
7 providers by ensuring that utilization review activities
8 result in informed decisions on the appropriateness of
9 medical care made by those best qualified to be involved in
10 the utilization review process.

11 <u>NEW SECTION.</u> Section 2. Definitions. As used in 12 [sections 1 through ±0 9] the following definitions apply:

13 (1) "Commissioner" means the commissioner of insurance14 provided for in 2-15-1903.

15 (2) "Health care provider" means a person, corporation,
16 facility, or institution licensed by the state to provide or
17 otherwise lawfully providing health care services, including
18 but not limited to:

19 (a) a physician, health care facility as defined in 20 50-5-101, osteopath, dentist. nurse, optometrist, 21 chiropractor, podiatrist, physical therapist, psychologist, 22 licensed social worker, speech pathologist, audiologist, certified chemical dependency counselor, 23 or licensed 24 professional counselor; AND

25 (b) an officer, employee, or agent of a person

-3-

SB 394

described in subsection (2)(a) acting in the course and
 scope of employment;-and

3 (c)--an--agency--related-to-or-supportive-of-health-care
4 services.

5 (3) "Health care services" means the health care and 6 services provided by health care providers, including 7 drugs, medicines, ambulance services, and other therapeutic 8 and rehabilitative services and supplies.

9 (4) "Utilization review" means a system for review of 10 health care services for a patient to determine the 11 necessity or appropriateness of services, whether that 12 review is prospective, concurrent, or retrospective, when 13 the review will be utilized directly or indirectly in order 14 to determine whether the health care services will be paid, 15 covered, or provided.

16(5) "UTILIZATION REVIEW AGENT" MEANS A PERSON OR ENTITY17PERFORMING UTILIZATION REVIEW EXCEPT AN AGENCY OF THE18FEDERAL GOVERNMENT OR AN AGENT ACTING ON BEHALF OF THE19FEDERAL GOVERNMENT TO THE EXTENT THE AGENT IS PROVIDING20SERVICES TO THE FEDERAL GOVERNMENT.

21 <u>NEW SECTION.</u> Section 3. Utilization review plan. A
22 person may not conduct a utilization review of health care
23 services provided or to be provided to a patient covered
24 under a contract or plan for health care services issued in
25 this state unless that person, at all times, maintains with

-4-

1	the commissioner a current utilization review plan that
2	includes:
3	(1) a description of review criteria, standards, and
4	procedures to be used in evaluating proposed or delivered
5	health care services that, to the extent possible, must:
6	(a) be based on nationally recognized criteria,
7	standards, and procedures;
8	(b) reflect community standards of care, EXCEPT THAT A
9	UTILIZATION REVIEW PLAN FOR HEALTH CARE SERVICES UNDER THE
10	GENERAL RELIEF MEDICAL ASSISTANCE OR MEDICAID PROGRAMS
11	PROVIDED FOR IN TITLE 53 NEED NOT REFLECT COMMUNITY
12	STANDARDS OF CARE;
13	(c) ensure quality of care; and
14	(d) ensure access to needed health care services;
15	(2) the provisions by which patients or providers may
16	seek reconsideration or appeal of adverse decisions by the
17	person conducting the utilization review;
18	(3) the type and qualifications of the personnel either
19	employed or under contract to perform the utilization
20	review;
21	(4) policies and procedures to ensure that a
22	representative of the person conducting the utilization
23	review is reasonably accessible to patients and health care
24	providers at all times;
25	(5) policies and procedures to ensure compliance with
	-5- SB 394

all applicable state and federal laws to protect the
 confidentiality of individual medical records;

3 (6) a copy of the materials designed to inform
 4 applicable patients and health care providers of the
 5 requirements of the utilization review plan; AND

6 (7)--a-list-of-the-persons-or-entities-for-whom-the
7 person-is-performing-utilization-reviews-in-this-state;-and
8 (0)(7) any other information as may be required by the
9 commissioner that is necessary to implement [sections 1
10 through 10 9].

11 <u>NEW SECTION.</u> Section 4. Conduct of utilization review.
12 A program of utilization review with regard to health care
13 services provided or to be provided in this state must
14 comply with the following:

15 (1) A determination adverse--to--a--patient--or--to--an 16 affected--health-care-provider-mav-not-be-made-on-a-guestion 17 relating BY A UTILIZATION REVIEW AGENT AS to the necessity or appropriateness for-a-health-care-service-without-prior 18 19 evaluation-and-concurrence-in-the-adverse--determination OF 20 AN ADMISSION, SERVICE, OR PROCEDURE MUST BE REVIEWED OR 21 DETERMINED IN ACCORDANCE WITH STANDARDS OR GUIDELINES 22 APPROVED by a physician.

(2) A determination regarding health care services
rendered or to be rendered to a patient that may result in a
denial of third-party reimbursement or a denial of

-6-

precettification for the service must include the written evaluation, findings, and concurrence of a physician trained in the relevan: specialty-or-subspecialty AREA OF HEALTH <u>CARE</u> to make it a final determination that the health care service rendered or to be rendered was, is, or may be medically inappropriate.

7 (3) A determination that health care services rendered 8 or to be rendered are medically inappropriate may not be 9 made unless the physician performing the utilization review 10 has consulted <u>MADE A REASONABLE ATTEMPT TO CONSULT</u> with the 11 patient's attending physician or other health care provider, 12 as the case may be, concerning the necessity or 13 appropriateness of the health care service.

NEW SECTION. Section 5. Presumption 14 of medical necessity. If a licensed physician certifies in writing to 15 an insurer within 72 hours of an admission that the insured 16 person admitted was in need of immediate care in a health 17 18 care facility, the certification constitutes a presumption 19 of the medical necessity of the admission. To overcome this 20 presumption, the entity requesting the utilization review or 21 the person conducting the utilization review shall show by 22 clear and convincing evidence that the admitted person was 23 not in need of immediate care in the health care facility.

24 <u>NEW SECTION.</u> Section 6. Appeal and assignment of
25 claim. (1) A patient or provider affected by an adverse

-7-

SB 394

decision has 30 days in which to appeal or seek
 reconsideration of the adverse decision by the person
 conducting the utilization review.

4 (2) A final decision on appeal or reconsideration must 5 be made within 30 days of receipt of the <u>ALL RELEVANT</u> 6 medical records by the person conducting the utilization 7 review and--not-less-than-60-days-following-the-request-for 8 appeal-or-reconsideration.

9 +3)--Notwithstanding--any--provision--to--the---contrary contained--in--a--contract--or-plan-for-health-care-benefits 10 issued--after---duly-1;---1991;---following---denial---after 11 utilization-review-and-appeal-or-reconsideration-as-provided 12 in--this--section,--a--claim-for-health-care-benefits-may-be 13 assigned-to-the-health-care-provider-by-the-covered-person. 14 NEW-SBCTION---Section-7---Persons-considered-engaged--in 15 16 practice--of--medicine---A-physician-who-reviews-health-care services-provided-or--to--be--provided--in--this--state--for 17 utilization--review--purposes-is-considered-to-be-engaged-in 18 19 the-practice-of-medicine-under-Title-377-chapter-37 20 NEW SECTION. Section 7. Commissioner to adopt rules.

<u>NEW SECTION.</u> Section 7. Commissioner to adopt rules.
 The commissioner shall <u>MAY</u> adopt rules for the
 implementation of [sections 1 through 10 9], including but
 not limited to rules providing for:

24 (1)--the-performance-of-utilization-review-activities;

25 (2)--procedures-for-reconsideration-or-appeal-of-adverse

-8-

SB 394

SB 0394/02

- 1 decisions-resulting-from-utilization-reviews; 1 fund, or preferred provider organization authorized to offer 2 (3)(1) information to be included in the utilization 2 health insurance policies or contracts; review plan required in [section 3]; 3 3 (ii) a health maintenance organization issued a (4)(2) utilization review criteria, standards, and 4 certificate of authority in accordance with Title 33, 4 5 procedures; and 5 chapter 31; or (5+(3)) the protection of the confidentiality of medical 6 6 (iii) a state agency. 7 records used in the course of utilization reviews. 7 (2) A general in-house utilization review for a health NEW SECTION. Section 8. Preemption of federal law. If 8 care provider, INCLUDING AN IN-HOUSE UTILIZATION REVIEW THAT 8 9 IS CONDUCTED BY OR FOR A LONG-TERM CARE FACILITY AND THAT IS any provision of [sections 1 through +0 9] is preempted OR 9 10 REQUIRED BY MEDICARE OR MEDICAID REGULATIONS, is exempt from DUPLICATED by federal law or regulations as applied to any 10 the provisions of [sections 1 through ± 0 9] as long as the 11 11 specific health care service, then the provision of 12 review does not DIRECTLY result in the approval or denial of [sections 1 through $\frac{1}{2}\theta$ 9] that is preempted OR DUPLICATED by 12 13 payment for health care services for a particular case. 13 federal law or regulations does not apply to that health 14 NEW SECTION. Section 10. Codification care service but only to the extent of the preemption OR instruction. 14 15 DUPLICATION. 15 [Sections 1 through 10 9] are intended to be codified as an 16 integral part of Title 33, and the provisions of Title 33 NEW SECTION. Section 9. Application --16 of act 17 apply to [sections 1 through ±0 9]. exemptions. (1) The provisions of [sections 1 through $\frac{1}{2}\theta = \frac{9}{2}$] 17 18 NEW-SECTION---Section-12---Effective-date--{This-act}-is 18 apply to a person or entity performing utilization reviews 19 effective-July-17-1991-19 who is, or is affiliated with, under contract with, or -End-20 acting on behalf of; 21 (a) a Montana business entity; or
- (b) a third party that provides or administers health
 care benefits to citizens of this state including:
- (i) a health insurer, nonprofit health service plan,health service corporation, employees' health and welfare

-9-

SB 394

-10-

25

1 SENATE BILL NO. 394 2 INTRODUCED BY SVRCEK, O'KEEFE, HOFFMAN, BENGTSON, KEATING, 3 WALLIN, JACOBSON, FRANKLIN, B. BROWN, CRIPPEN, RUSSELL, 4 BROOKE, D. BROWN 5 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT 6 7 OF UTILIZATION REVIEWS BY HEALTH INSURERS AND OTHER THIRD-PARTY PAYORS; TO PROHIBIT A PERSON FROM CONDUCTING 8 9 UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE 10 COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN; TO 11 PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF 12 UTILIZATION REVIEWS BY REQUIRING CONCURRENCE OF A PHYSICIAN 13 IN A DETERMINATION RELATING TO THE NECESSITY OR APPROPRIATENESS OF HEALTH CARE SERVICES RENDERED TO A 14 15 PATIENT: TO-PROVIDE-A-PRESUMPTION-OF--MEDICAL--NECESSITY--OP 16 Health--Care--Services--if--An--insured-Person-is-in-Need-Op 17 IMMEDIATE-ADMISSION-TO-A-HEASTH-CARE--FACISITY; TO PROVIDE 18 FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM A 19 UTILIZATION REVIEW; AND TO AUTHORIZE THE COMMISSIONER OF 20 INSURANCE TO ADOPT RULES; -AND-PROVIDING-AN-EPPECTIVE-DATE." 21 22 STATEMENT OF INTENT 23 A statement of intent is required for this bill because 24 [section 8 7] requires AUTHORIZES the commissioner of

insurance to adopt rules for the purpose of implementing



1 [sections 1 through 10 9]. 2 It is the intent of the legislature that the 3 commissioner of insurance adopt rules necessary for the 4 regulation of utilization reviews in this state. Rules 5 adopted by the commissioner may include but are not limited 6 to rules providing for: 7 (1)--the-performance-of-utilization-review-activities; (2)--procedures-for-reconsideration-or-appeal-of-adverse 8 ٩ decisions-resulting-from-utilization-reviews; 10 (3)(1) information to be included in the utilization 11 review plan required in [section 3]; 12

12 (4)(2) utilization review criteria, standards, and 13 procedures; and

the protection of the confidentiality of medical
 records used in the course of utilization reviews.

Rules adopted by the commissioner of insurance must be consistent with the purposes of this bill as stated in [section 1] and must supplement the provisions of [sections 19 1 through 10 9].

20

21 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Purpose. The legislature finds
and declares that it is the purpose of [sections 1 through
10 9] to:

25 (1) promote the delivery of quality health care in a

-2-

SB 394 THIRD READING AS AMENDED

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1 cost-effective manner;

2 (2) foster greater coordination between health care
3 providers, third-party payors, and others who conduct
4 utilization review activities;

5 (3) ensure access to health care services; and

6 (4) protect patients, employers, and health care 7 providers by ensuring that utilization review activities 8 result in informed decisions on the appropriateness of 9 medical care made by those best qualified to be involved in 10 the utilization review process.

11 <u>NEW SECTION.</u> Section 2. Definitions. As used in 12 [sections 1 through ±0 9] the following definitions apply:

13 (1) "Commissioner" means the commissioner of insurance14 provided for in 2-15-1903.

15 (2) "Health care provider" means a person, corporation,
16 facility, or institution licensed by the state to provide or
17 otherwise lawfully providing health care services, including
18 but not limited to:

(a) a physician, health care facility as defined in
50-5-101, osteopath, dentist, nurse, optometrist,
chiropractor, podiatrist, physical therapist, psychologist,
licensed social worker, speech pathologist, audiologist,
certified chemical dependency counselor, or licensed
professional counselor; <u>AND</u>

25 (b) an officer, employee, or agent of a person

2 scope of employment₇-and 3 (c)--an--agency--related-to-or-supportive-of-health-care

4 services.

described in subsection (2)(a) acting in the course and

5 (3) "Health care services" means the health care and 6 services provided by health care providers, including 7 drugs, medicines, ambulance services, and other therapeutic 8 and rehabilitative services and supplies.

9 (4) "Utilization review" means a system for review of 10 health care services for a patient to determine the 11 necessity or appropriateness of services, whether that 12 review is prospective, concurrent, or retrospective, when 13 the review will be utilized directly or indirectly in order 14 to determine whether the health care services will be paid, 15 covered, or provided.

16(5) "UTILIZATION REVIEW AGENT" MEANS A PERSON OR ENTITY17PERFORMING UTILIZATION REVIEW EXCEPT AN AGENCY OF THE18FEDERAL GOVERNMENT OR AN AGENT ACTING ON BEHALF OF THE19FEDERAL GOVERNMENT TO THE EXTENT THE AGENT IS PROVIDING20SERVICES TO THE FEDERAL GOVERNMENT.21NEW SECTION. Section 3. Utilization review plan. A

22 person may not conduct a utilization review of health care 23 services provided or to be provided to a patient covered 24 under a contract or plan for health care services issued in 25 this state unless that person, at all times, maintains with

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SB 394

-4-

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1 the commissioner a current utilization review plan that 2 includes: 3 (1) a description of review criteria, standards, and 4 procedures to be used in evaluating proposed or delivered 5 health care services that, to the extent possible, must: 6 (a) be based on nationally recognized criteria, 7 standards, and procedures; 8 (b) reflect community standards of care, EXCEPT THAT A 9 UTILIZATION REVIEW PLAN FOR HEALTH CARE SERVICES UNDER THE 10 GENERAL RELIEF MEDICAL ASSISTANCE OR MEDICAID PROGRAMS PROVIDED FOR IN TITLE 53 NEED NOT REFLECT COMMUNITY 11 12 STANDARDS OF CARE; 13 (c) ensure quality of care; and 14 (d) ensure access to needed health care services; 15 (2) the provisions by which patients or providers may 16 seek reconsideration or appeal of adverse decisions by the 17 person conducting the utilization review; 18 (3) the type and gualifications of the personnel either 19 employed or under contract to perform the utilization 20 review; 21 (4) policies and procedures to that a ensure 22 representative of the person conducting the utilization 23 review is reasonably accessible to patients and health care 24 providers at all times; 25 (5) policies and procedures to ensure compliance with SB 394 -5-

3 (6) a copy of the materials designed to inform 4 applicable patients and health care providers of the 5 requirements of the utilization review plan; AND 6 17)--a--list--of--the--persons--or-entities-for-whom-the 7 person-is-performing-utilization-reviews-in-this-state;-and 8 (8)(7) any other information as may be required by the 9 commissioner that is necessary to implement [sections] 10 through ± 0 9].

confidentiality of individual medical records;

all applicable state and federal laws to protect the

 NEW SECTION.
 Section 4.
 Conduct of utilization review.

 A program of utilization review with regard to health care
 services provided or to be provided in this state must

 comply with the following:
 (1) A determination adverse-to--a--patient--or-to--an

16 affected--health-care-provider-may-not-be-made-on-a-question 17 relating <u>BY A UTILIZATION REVIEW AGENT AS</u> to the necessity 18 or appropriateness for-a-health-care-service-without-prior 19 evaluation-and-concurrence-in-the-adverse--determination <u>OF</u> 20 <u>AN ADMISSION, SERVICE, OR PROCEDURE MUST BE REVIEWED OR</u> 21 <u>DETERMINED IN ACCORDANCE WITH STANDARDS OR GUIDELINES</u> 22 <u>APPROVED</u> by a physician.

(2) A determination regarding health care services
rendered or to be rendered to a patient that may result in a
denial of third-party reimbursement or a denial of

-6-

1 precertification for the service must include the written evaluation, findings, and concurrence of a physician trained 2 3 in the relevant specialty-or-subspecialty AREA OF HEALTH 4 CARE to make it a final determination that the health care 5 service rendered or to be rendered was, is, or may be 6 medically inappropriate.

7 (3) A determination that health care services rendered 8 or to be rendered are medically inappropriate may not be 9 made unless the physician performing the utilization review 10 has consulted MADE A REASONABLE ATTEMPT TO CONSULT with the 11 patient's attending physician or other health care provider, 12 as the case may be, concerning the necessity or 13 appropriateness of the health care service.

14 NEW-SECTIOn---Section-5---Presumption----of----medical 15 necessity;--If-a-licensed-physician-certifies-in--writing-to 16 an-insurer-within-72-hours-of-an-admission-that-the--insured 17 person--admitted--was--in-need-of-immediate-care-in-a-health 18 care-facility;-the-certification-constitutes--a--presumption 19 of--the-medical-necessity-of-the-admission--To-overcome-this 20 presumptiony-the-entity-requesting-the-utilization-review-or 21 the-person-conducting-the-utilization-review-shall--show--by 22 clear--and--convincing-evidence-that-the-admitted-person-was 23 not-in-need-of-immediate-care-in-the-health-care-facility-NEW SECTION. SECTION 5. COMMISSIONER NOT TO APPROVE OR 24

25 DISAPPROVE PLANS. NOTHING IN [SECTIONS 1 THROUGH 9] MAY BE 1 CONSTRUED AS AUTHORIZING THE COMMISSIONER TO APPROVE OR 2 DISAPPROVE A UTILIZATION REVIEW PLAN REQUIRED IN (SECTION 3 3].

4 NEW SECTION. Section 6. Appeal and assignment o£ 5 claim. (1) A patient or provider affected by an adverse 6 decision has 30 days in which to appeal or seek 7 reconsideration of the adverse decision by the person **R** conducting the utilization review.

9 (2) A final decision on appeal or reconsideration must 10 be made within 30 days of receipt of the ALL RELEVANT 11 medical records by the person conducting the utilization 12 review and-not-less-than-60-days-following-the--request--for 13 appeal-or-reconsideration-

14 (3)--Notwithstanding---any--provision--to--the--contrary 15 contained-in-a-contract-or-plan--for--health--care--benefits 16 issued---after---July-17---19917---following---denial--after 17 utilization-review-and-appeal-or-reconsideration-as-provided 18 in-this-section--a-claim-for-health--care--benefits--may--be 19 assigned-to-the-health-care-provider-by-the-covered-person. 20 NEW-SECTION---Section-7---Persons--considered-engaged-in 21 practice-of-medicine--A-physician-who--reviews--health--care 22 services--provided--or--to--be--provided--in--this-state-for 23 utilization-review-purposes-is-considered-to-be--engaged--in 24 the-practice-of-medicine-under-Title-377-chapter-3-25 NEW SECTION. Section 7. Commissioner to adopt rules.

SB 0394/03

The commissioner shall MAY adopt rules for the
 implementation of [sections 1 through 10 9], including but
 not limited to rules providing for:

4 (1)--the-performance-of-utilization-review-activities;

5 (2)--procedures-for-reconsideration-or-appeal-of-adverse
 6 decisions-resulting-from-utilization-reviews;

7 (3)(1) information to be included in the utilization
8 review plan required in [section 3];

9 (4)(2) utilization review criteria, standards, and 10 procedures; and

11 (5)(3) the protection of the confidentiality of medical 12 records used in the course of utilization reviews.

13 NEW SECTION. Section 8. Preemption of federal law. If 14 any provision of [sections 1 through 10 9] is preempted OR DUPLICATED by federal law or regulations as applied to any 15 specific health care service, then the provision of 16 [sections 1 through 10 9] that is preempted OR DUPLICATED by 17 18 federal law or regulations does not apply to that health 19 care service but only to the extent of the preemption OR 20 DUPLICATION.

21 <u>NEW SECTION.</u> Section 9. Application of act --22 exemptions. (1) The provisions of [sections 1 through $\frac{10}{29}$] 23 apply to a person or entity performing utilization reviews 24 who is, or is affiliated with, under contract with, or 25 acting on behalf of; (a) a Montana business entity; or

2 (b) a third party that provides or administers health3 care benefits to citizens of this state including:

4 (i) a health insurer, nonprofit health service plan, 5 health service corporation, employees' health and welfare 6 fund, or preferred provider organization authorized to offer 7 health insurance policies or contracts;

8 (ii) a health maintenance organization issued a
9 certificate of authority in accordance with Title 33,
10 chapter 31; or

11 (iii) a state agency.

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(2) A general in-house utilization review for a health
care provider, INCLUDING AN IN-HOUSE UTILIZATION REVIEW THAT
IS CONDUCTED BY OR FOR A LONG-TERM CARE FACILITY AND THAT IS
REQUIRED BY MEDICARE OR MEDICAID REGULATIONS, is exempt from
the provisions of [sections 1 through i0 9] as long as the
review does not <u>DIRECTLY</u> result in the approval or denial of

18 payment for health care services for a particular case.

19NEW SECTION.Section 10. Codificationinstruction.20[Sections 1 through $\frac{10}{9}$] are intended to be codified as an21integral part of Title 33, and the provisions of Title 3322apply to [sections 1 through $\frac{10}{9}$].

23 NEW-SECTION---Section-12---Effective-date--{This-act}-is

24 effective-July-17-1991-

-End-

-10-

-9-

SB 394

HOUSE STANDING COMMITTEE REPORT

March 21, 1991 Page 1 of 2

Mr. Speaker: We, the committee on <u>Business and Economic</u> <u>Development</u> report that <u>Senate Bill 394</u> (third reading copy -- blue) be concurred in as amended.

Signed: Chairman

And, that such amendments read: 1. Title, line 12. Strike: "PHYSICIAN" Insert: "HEALTH CARE PROFESSIONAL"

2. Page 4, line 15.

Following: "provided."

Insert: "Utilization review does not include routine claim administration or determination that does not include determinations of medical necessity or appropriateness."

3. Page 4, lines 16 through 20. Strike: subsection (5) in its entirety

4. Page 6, line 17.

- Strike: "BY A UTILIZATION REVIEW AGENT AS"
- Insert: "that is made on appeal or reconsideration as provided in [section 6] and that is adverse to a patient or to an affected health care provider may not be made on a question relating"

5. Page 6, lines 20 through 22.

Strike: lines 20 through 22 in their entirety

Insert: "a health care service without prior written findings, evaluation, and concurrence in the adverse determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence must be provided to the patient on request as provided in Title 33, chapter 19."

6. Page 6, line 23 through page 7, line 6. Strike: subsection (2) in its entirety Renumber: subsequent subsection 7. Page 7, line 7. Following: "determination" Insert: "made on appeal or reconsideration, as provided in [section 6],"

8. Page 7, line 9. Strike: "physician" Insert: "health care professional"

9. Page 7, line 11. Strike: "physician or other"

10. Page 7, lines 11 and 12. Strike: ", as the case may be,"

11. Page 8, line 6.
Following: "has"
Insert: "at least"

12. Page 8, line 10. Insert: "30" Insert: "60"

13. Page 10, line 19. Following: line 18 Insert: "(3) A peer review procedure conducted by a professional society or association of providers is exempt from the provisions of [sections 1 through 9]."

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March 21, 1991 Page 2 of 2

52nd Legislature

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SB 0394/04

1 SENATE BILL NO. 394 2 INTRODUCED BY SVRCEK, O'KEEFE, HOFFMAN, BENGTSON, KEATING, 3 WALLIN, JACOBSON, FRANKLIN, B. BROWN, CRIPPEN, RUSSELL, BROOKE, D. BROWN Δ 5 6 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT 7 OF UTILIZATION REVIEWS BY HEALTH INSURERS AND OTHER 8 THIRD-PARTY PAYORS; TO PROHIBIT A PERSON FROM CONDUCTING 9 UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE 10 COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN: TO PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF 11 12 UTILIZATION REVIEWS BY REOUIRING CONCURRENCE OF A PHYSICIAN 13 HEALTH CARE PROFESSIONAL IN A DETERMINATION RELATING TO THE 14 NECESSITY OR APPROPRIATENESS OF HEALTH CARE SERVICES 15 RENDERED TO A PATIENT; TO-PROVIDE-A-PRESUMPTION-OF-MEDICAL 16 NECESSITY-OF-HEALTH-CARE-SERVICES-IF-AN-INSURED-PERSON-IS-IN 17 NEED-OF-IMMEDIATE-ADMISSION-TO-A-HEALTH--CARE--FACILITY; TO 18 PROVIDE FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM 19 A UTILIZATION REVIEW; AND TO AUTHORIZE THE COMMISSIONER OF 20 INSURANCE TO ADOPT RULES; -AND-PROVIDING-AN-EPPBCTIVE-DATE."

21 22

STATEMENT OF INTENT

23 A statement of intent is required for this bill because 24 [section θ <u>7</u>] requires <u>AUTHORIZES</u> the commissioner of 25 insurance to adopt rules for the purpose of implementing

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SB 0394/04

1	[sections 1 through ±0 9].
2	It is the intent of the legislature that the
3	commissioner of insurance adopt rules necessary for the
4	regulation of utilization reviews in this state. Rules
5	adopted by the commissioner may include but are not limited
6	to rules providing for:
7	<pre>tlpthe-performance-of-utilization-review-activities;</pre>
8	<pre>(2)procedures-for-reconsideration-or-appeal-of-adverse</pre>
9	decisions-resulting-from-utilization-reviews;
10	+3+(1) information to be included in the utilization
11	review plan required in [section 3];
12	<pre>t47(2) utilization review criteria, standards, and</pre>
13	procedures; and
14	(5)[3] the protection of the confidentiality of medical
15	records used in the course of utilization reviews.
16	Rules adopted by the commissioner of insurance must be
17	consistent with the purposes of this bill as stated in
18	[section 1] and must supplement the provisions of [sections
19	1 through ±0 9].
20	
21	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
22	NEW SECTION. Section 1. Purpose. The legislature finds
23	and declares that it is the purpose of [sections 1 through
24	±0 9] to:
25	(1) promote the delivery of quality health care in a

-2-

SB 394 REFERENCE BILL AS AMENDED

1 cost-effective manner;

25

2 (2) foster greater coordination between health care
3 providers, third-party payors, and others who conduct
4 utilization review activities;

5 (3) ensure access to health care services; and

6 (4) protect patients, employers, and health care
7 providers by ensuring that utilization review activities
8 result in informed decisions on the appropriateness of
9 medical care made by those best gualified to be involved in
10 the utilization review process.

11 <u>NEW SECTION.</u> Section 2. Definitions. As used in 12 [sections 1 through 10 9] the following definitions apply:

13 (1) "Commissioner" means the commissioner of insurance14 provided for in 2-15-1903.

15 (2) "Health care provider" means a person, corporation,
16 facility, or institution licensed by the state to provide or
17 otherwise lawfully providing health care services, including
18 but not limited to:

(a) a physician, health care facility as defined in
50-5-101, osteopath, dentist, nurse, optometrist,
chiropractor, podiatrist, physical therapist, psychologist,
licensed social worker, speech pathologist, audiologist,
certified chemical dependency counselor, or licensed
professional counselor; <u>AND</u>

(b) an officer, employee, or agent of a person

1 described in subsection (2)(a) acting in the course and 2 scope of employment₇-and

3 (c)--an-agency-related-to-or-supportive-of--health--care 4 services.

5 (3) "Health care services" means the health care and 6 services provided by health care providers, including 7 drugs, medicines, ambulance services, and other therapeutic 8 and rehabilitative services and supplies.

(4) "Utilization review" means a system for review of 9 10 health care services for a patient to determine the necessity or appropriateness of services, whether that 11 12 review is prospective, concurrent, or retrospective, when 13 the review will be utilized directly or indirectly in order 14 to determine whether the health care services will be paid, 15 covered, or provided. UTILIZATION REVIEW DOES NOT INCLUDE 16 ROUTINE CLAIM ADMINISTRATION OR DETERMINATION THAT DOES NOT 17 INCLUDE DETERMINATIONS OF MEDICAL NECESSITY OR

18 APPROPRIATENESS.

 19
 <u>f5}--*UTILIEATION-REVIEW-AGENT*-MEANS-A-PERSON-OR-ENTITY</u>

 20
 PERFORMING--UTILIEATION--REVIEW--EXCEPT--AN-AGENCY--OF--THE

21 PEDERAL--GOVERNMENT--OR--AN--AGENT--ACTING--ON-BEHALF-OF-THE

22 PEBERAL-GOVERNMENT-TO-THE--EXTENT--THE--AGENT--IS--PROVIDING

23 SERVICES-TO-THE-FEDERAL-GOVERNMENT

24 <u>NEW SECTION.</u> Section 3. Utilization review plan. A
25 person may not conduct a utilization review of health care

-4-

-3-

SB 394

services provided or to be provided to a patient covered
 under a contract or plan for health care services issued in
 this state unless that person, at all times, maintains with
 the commissioner a current utilization review plan that
 includes:

6 (1) a description of review criteria, standards, and
7 procedures to be used in evaluating proposed or delivered
8 health care services that, to the extent possible, must:

9 (a) be based on nationally recognized criteria,10 standards, and procedures;

11 (b) reflect community standards of care, EXCEPT THAT A
12 UTILIZATION REVIEW PLAN FOR HEALTH CARE SERVICES UNDER THE
13 GENERAL RELIEF MEDICAL ASSISTANCE OR MEDICAID PROGRAMS
14 PROVIDED FOR IN TITLE 53 NEED NOT REFLECT COMMUNITY
15 STANDARDS OF CARE;

16 (c) ensure quality of care; and

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17 (d) ensure access to needed health care services;

18 (2) the provisions by which patients or providers may
19 seek reconsideration or appeal of adverse decisions by the
20 person conducting the utilization review;

21 (3) the type and qualifications of the personnel either 22 employed or under contract to perform the utilization 23 review;

24 (4) policies and procedures to ensure that a25 representative of the person conducting the utilization

review is reasonably accessible to patients and health care
 providers at all times;

3 (5) policies and procedures to ensure compliance with
4 all applicable state and federal laws to protect the
5 confidentiality of individual medical records;

6 (6) a copy of the materials designed to inform
7 applicable patients and health care providers of the
8 requirements of the utilization review plan; <u>AND</u>

9 (7)--a-list-of-the-persons-or-entities-for-whom-the 10 person-is-performing-utilization-reviews-in-this-state;-and 11 (8)(7) any other information as may be required by the 12 commissioner that is necessary to implement [sections 1]

13 through $\pm \theta$ 9].

14NEW SECTION.Section 4. Conduct of utilization review.15A program of utilization review with regard to health care16services provided or to be provided in this state must17comply with the following:

18 (1) A determination adverse-to-a-patient-or-to-an
affected--health-care-provider-may-not-be-made-on-a-question
relating <u>BY-A-UTIBIBATION-REVIEW-AGENT-AS</u> THAT IS MADE ON
21 <u>APPEAL OR RECONSIDERATION AS PROVIDED IN [SECTION 6] AND</u>
22 <u>THAT IS ADVERSE TO A PATIENT OR TO AN AFFECTED HEALTH CARE</u>
23 <u>PROVIDER MAY NOT BE MADE ON A QUESTION RELATING</u> to the

24 necessity or appropriateness for--a--health--care--service

25 without--prior--evaluation--and--concurrence--in-the-adverse

-6-

-5-

SB 394

SB 394

SB 0394/04

determination OF AN-ADMISSIONy-SERVICE7-OR-PROCEDURE-MUST-BE
REVIEWED-ORDETERMINEDINACCORDANCEWITHSTANDARDSOR
GUIDELINESAPPROVED bya-physician: A REALTH CARE SERVICE
WITHOUT PRIOR WRITTEN FINDINGS, EVALUATION, AND CONCURRENCE
IN THE ADVERSE DETERMINATION BY A HEALTH CARE PROFESSIONAL
TRAINED IN THE RELEVANT AREA OF HEALTH CARE. COPIES OF THE
WRITTEN FINDINGS, EVALUATION, AND CONCURRENCE MUST BE
PROVIDED TO THE PATIENT ON REQUEST AS PROVIDED IN TITLE 33,
CHAPTER 19.
(2)Adeterminationregardinghealthcareservice:
rendered-or-to-be-rendered-to-a-patient-that-may-result-in-a

12 denial---of---third-party---reimbursement--or--a--denial--of 13 precertification-for-the-service-must--include--the--written 14 evaluation,-findings,-and-concurrence-of-a-physician-trained 15 in--the--relevant--specialty--or-subspecialty <u>AREA-OP-HEALTH</u> 16 <u>EARE</u> to-make-it-a-final-determination-that-the--health--care 17 service--rendered--or--to--be--rendered--was,--is,-or-may-be 18 medically-inappropriate-

19 (3)(2) A determination MADE ON APPEAL OR RECONSIDERATION, AS PROVIDED IN [SECTION 6], that health 20 21 care services rendered or to be rendered are medically 22 inappropriate may not be made unless the physician HEALTH 23 CARE PROFESSIONAL performing the utilization review has 24 consulted MADE A REASONABLE ATTEMPT TO CONSULT with the patient's attending physician-or-other health care provider; 25

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1	asthecasemaybe; concerning the necessity or
2	appropriateness of the health care service.
3	<u>NEW-SECTION.</u> Section-5:Presumptionofmedical
4	necessityif-a-licensed-physician-certifies-inwritingto
5	aninsurer-within-72-hours-of-an-admission-that-the-insured
6	person-admitted-was-in-need-of-immediate-careinahealth
7	carefacilitythe-certification-constitutes-a-presumption
8	of-the-medical-necessity-of-the-admissionTo-overcomethis
9	presumption,-the-entity-requesting-the-utilization-review-or
10	thepersonconducting-the-utilization-review-shall-show-by
11	clear-and-convincing-evidence-that-the-admittedpersonwas
12	not-in-need-of-immediate-care-in-the-health-care-facility-
13	NEW SECTION. SECTION 5. COMMISSIONER NOT TO APPROVE OR
14	DISAPPROVE PLANS. NOTHING IN [SECTIONS 1 THROUGH 9] MAY BE
15	CONSTRUED AS AUTHORIZING THE COMMISSIONER TO APPROVE OR
ТJ	CONDITION NO NOTIONITATINO IND CONTRODUCTION IN
16	DISAPPROVE A UTILIZATION REVIEW PLAN REQUIRED IN (SECTION
17	<u>31.</u>
18	NEW SECTION. Section 6. Appeal and assignment of

19 claim. (1) A patient or provider affected by an adverse 20 decision has <u>AT LEAST</u> 30 days in which to appeal or seek 21 reconsideration of the adverse decision by the person 22 conducting the utilization review.

23 (2) A final decision on appeal or reconsideration must 24 be made within 3θ <u>60</u> days of receipt of the <u>ALL RELEVANT</u> 25 medical records by the person conducting the utilization

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SB 394

SB 0394/04

-8-

review and--not-less-than-60-days-following-the-request-for 1 2 appeal-or-reconsideration-(3)--Notwithstanding--any--provision--to--the---contrary 3 contained--in--a--contract--or-plan-for-health-care-benefits 4 5 issued--after---duly-17---19917---following---denial---after utilization-review-and-appeal-or-reconsideration-as-provided 6 7 in--this--section---a--claim-for-health-care-benefits-may-be assigned-to-the-health-care-provider-by-the-covered-person. 8 9 NEW-SECTION---Section-7---Persons-considered-engaged--in 10 practice--of--medicine---A-physician-who-reviews-health-care 11 services-provided-or--to--be--provided--in--this--state--for utilization--review--purposes-is-considered-to-be-engaged-in 12 the-practice-of-medicine-under-Title-377-chapter-37 13 NEW SECTION. Section 7. Commissioner to adopt rules. 14 MAY adopt rules for the 15 The commissioner shall implementation of [sections 1 through ± 0 9], including but 16 17 not limited to rules providing for: {1}--the-performance-of-utilization-review-activities; 18 19 +2}--procedures-for-reconsideration-or-appeal-of-adverse 20 decisions-resulting-from-utilization-reviews; 21 (+3)(1) information to be included in the utilization 22 review plan required in [section 3]; (4)(2) utilization review criteria, standards, and 23 procedures; and 24 (5)(3) the protection of the confidentiality of medical 25

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1 records used in the course of utilization reviews.

2	NEW SECTION. Section 8. Preemption of federal law. If
3	any provision of [sections 1 through $\frac{10}{29}$ is preempted <u>OR</u>
4	DUPLICATED by federal law or regulations as applied to any
5	specific health care service, then the provision of
6	[sections 1 through ± 0 9] that is preempted <u>OR DUPLICATED</u> by
7	federal law or regulations does not apply to that health
8	care service but only to the extent of the preemption OR
9	DUPLICATION.
10	NEW SECTION. Section 9. Application of act
11	exemptions. (1) The provisions of [sections 1 through $10 - 9$]
12	apply to a person or entity performing utilization reviews
13	who is, or is affiliated with, under contract with, or
14	acting on behalf of;
15	(a) a Montana business entity; or
16	(b) a third party that provides or administers health
17	care benefits to citizens of this state including:
18	(i) a health insurer, nonprofit health service plan,
19	health service corporation, employees' health and welfare
20	fund, or preferred provider organization authorized to offer
21	health insurance policies or contracts;
22	(ii) a health maintenance organization issued a
23	certificate of authority in accordance with Title 33,

-10-

24 chapter 31; or

25 (iii) a state agency.

SB 0394/04

SB 394

-9-

1	(2) A general in-house utilization review for a health
2	care provider, INCLUDING AN IN-HOUSE UTILIZATION REVIEW THAT
3	IS CONDUCTED BY OR FOR A LONG-TERM CARE FACILITY AND THAT IS
4	REQUIRED BY MEDICARE OR MEDICAID REGULATIONS, is exempt from
5	the provisions of [sections 1 through $\pm \theta$ 9] as long as the
6	review does not DIRECTLY result in the approval or denial of
7	payment for health care services for a particular case.
8	(3) A PEER REVIEW PROCEDURE CONDUCTED BY A PROFESSIONAL
9	SOCIETY OR ASSOCIATION OF PROVIDERS IS EXEMPT FROM THE
10	PROVISIONS OF [SECTIONS 1 THROUGH 9].
11	NEW SECTION. Section 10. Codification instruction.
12	[Sections 1 through $\pm \theta$ 9] are intended to be codified as an
13	integral part of Title 33, and the provisions of Title 33
14	apply to [sections 1 through $\frac{1}{2}\theta$ 9].
15	NEW-SECTIONSection-12Effective-date{This-act}-is
16	effective-July-17-1991;

-End-

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