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	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
	FIRST READING.
FEBRUARY 23, 1991	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 25, 1991	PRINTING REPORT.
	SECOND READING, DO PASS AS AMENDED.
FEBRUARY 26, 1991	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 43; NOES, 6.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 4, 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.
APRIL 6, 1991	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.
APRIL 18, 1991	THIRD READING, AMENDMENTS CONCURRED IN.
APRIL 19, 1991	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

1 Senate BILL NO. 394
2 INTRODUCED BY Smith, [illegible], Hoffman, Bengtson, [illegible]
3 [illegible], Franklin, Bob Brown, [illegible], Russell, [illegible]
4 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT
5 OF UTILIZATION REVIEWS BY HEALTH INSURERS AND OTHER
6 THIRD-PARTY PAYORS; TO PROHIBIT A PERSON FROM CONDUCTING
7 UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE
8 COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN; TO
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
15 IMMEDIATE ADMISSION TO A HEALTH CARE FACILITY; TO PROVIDE
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
21 A statement of intent is required for this bill because
22 [section 8] requires the commissioner of insurance to adopt
23 rules for the purpose of implementing [sections 1 through
24 10].
25 It is the intent of the legislature that the

1 commissioner of insurance adopt rules necessary for the
2 regulation of utilization reviews in this state. Rules
3 adopted by the commissioner may include but are not limited
4 to rules providing for:
5 (1) the performance of utilization review activities;
6 (2) procedures for reconsideration or appeal of adverse
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
15 consistent with the purposes of this bill as stated in
16 [section 1] and must supplement the provisions of [sections
17 1 through 10].
18
19 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
20 NEW SECTION. **Section 1. Purpose.** The legislature finds
21 and declares that it is the purpose of [sections 1 through
22 10] to:
23 (1) promote the delivery of quality health care in a
24 cost-effective manner;
25 (2) foster greater coordination between health care

INTRODUCED BILL
SB 394

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 NEW SECTION. **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.
13 (2) "Health care provider" means a person, corporation,
14 facility, or institution licensed by the state to provide or
15 otherwise lawfully providing health care services, including
16 but not limited to:
17 (a) a physician, health care facility as defined in
18 50-5-101, osteopath, dentist, nurse, optometrist,
19 chiropractor, podiatrist, physical therapist, psychologist,
20 licensed social worker, speech pathologist, audiologist,
21 certified chemical dependency counselor, or licensed
22 professional counselor;
23 (b) an officer, employee, or agent of a person
24 described in subsection (2)(a) acting in the course and
25 scope of employment; and

1 (c) an agency related to or supportive of health care
2 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 NEW SECTION. **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:
21 (1) a description of review criteria, standards, and
22 procedures to be used in evaluating proposed or delivered
23 health care services that, to the extent possible, must:
24 (a) be based on nationally recognized criteria,
25 standards, and procedures;

1 (b) reflect community standards of care;
2 (c) ensure quality of care; and
3 (d) ensure access to needed health care services;
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
13 providers at all times;
14 (5) policies and procedures to ensure compliance with
15 all applicable state and federal laws to protect the
16 confidentiality of individual medical records;
17 (6) a copy of the materials designed to inform
18 applicable patients and health care providers of the
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
3 comply with the following:
4 (1) A determination adverse to a patient or to an
5 affected health care provider may not be made on a question
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
19 made unless the physician performing the utilization review
20 has consulted with the patient's attending physician or
21 other health care provider, as the case may be, concerning
22 the necessity or appropriateness of the health care service.
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

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.

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

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

(3) Notwithstanding any provision to the contrary contained in a contract or plan for health care benefits issued after July 1, 1991, following denial after utilization review and appeal or reconsideration as provided in this section, a claim for health care benefits may be assigned to the health care provider by the covered person.

NEW SECTION. **Section 7. Persons considered engaged in 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.

NEW SECTION. **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:

(1) the performance of utilization review activities;

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

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

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

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

NEW SECTION. **Section 9. Preemption of federal law.** If any provision of [sections 1 through 10] is preempted by federal law or regulations as applied to any specific health care service, then the provision of [sections 1 through 10] that is preempted by federal law or regulations does not apply to that health care service but only to the extent of the preemption.

NEW SECTION. **Section 10. Application of act -- exemptions.** (1) The provisions of [sections 1 through 10]

1 apply to a person or entity performing utilization reviews
2 who is, or is affiliated with, under contract with, or
3 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 NEW SECTION. **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 NEW SECTION. **Section 12.** Effective date. [This act] is
25 effective July 1, 1991.

-End-

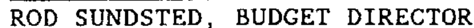
STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0394, third reading.

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		
Expenditures:	Current Law	Proposed Law	Difference	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)	0	30,250	30,250	0	33,946	33,946
Total	0	41,667	41,667	0	45,261	45,261
General Fund Impact (Decrease)			(11,417)			(11,315)


3-13-91
ROD SUNDSTED, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

3/14/91
PAUL S. SVRCEK, PRIMARY SPONSOR DATE

Fiscal Note for SB0394, third reading

SB 394-1

APPROVED BY COMM. ON
BUSINESS & INDUSTRY

SENATE BILL NO. 394

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

A BILL FOR AN ACT ENTITLED: "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-A-PRESUMPTION-OF--MEDICAL--NECESSITY--OF HEALTH--CARE--SERVICES--IF--AN--INSURED-PERSON-IS-IN-NEED-OF IMMEDIATE-ADMISSION-TO-A-HEALTH-CARE--FACILITY;~~ TO PROVIDE FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM A UTILIZATION REVIEW; AND TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ADOPT RULES~~;-AND-PROVIDING-AN-EFFECTIVE-DATE~~."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section ~~8~~ 7] ~~requires~~ AUTHORIZES the commissioner of insurance to adopt rules for the purpose of implementing

[sections 1 through ~~10~~ 9].

It is the intent of the legislature that the commissioner of insurance adopt rules necessary for the regulation of utilization reviews in this state. Rules adopted by the commissioner may include but are not limited to rules providing for:

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

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

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

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

~~(5)~~(3) 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 1 through ~~10~~ 9].

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:

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

SECOND READING

cost-effective manner;

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

(3) ensure access to health care services; and

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

NEW SECTION. **Section 2.** **Definitions.** As used in [sections 1 through ~~10~~ 9] the following definitions apply:

(1) "Commissioner" means the commissioner of insurance 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 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; AND

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

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

(5) "UTILIZATION REVIEW AGENT" MEANS A PERSON OR ENTITY PERFORMING UTILIZATION REVIEW EXCEPT AN AGENCY OF THE FEDERAL GOVERNMENT OR AN AGENT ACTING ON BEHALF OF THE FEDERAL GOVERNMENT TO THE EXTENT THE AGENT IS PROVIDING SERVICES TO THE FEDERAL GOVERNMENT.

NEW SECTION. **Section 3.** **Utilization review plan.** A person may not conduct a utilization review of health care 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:

(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:

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

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

(c) ensure quality of care; and

(d) ensure access to needed health care services;

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

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

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

(5) policies and procedures to ensure compliance with

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

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

~~(7)--a--list--of--the--persons--or--entities-for-whom-the person-is-performing-utilization-reviews-in-this-state;-and~~

~~(8)~~(7) any other information as may be required by the commissioner that is necessary to implement [sections 1 through ~~10~~ 9].

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 affected--health-care-provider-may-not-be-made-on-a-question relating~~ BY A UTILIZATION REVIEW AGENT AS to the necessity or appropriateness ~~for-a-health-care-service-without-prior evaluation-and-concurrence-in-the-adverse--determination~~ OF AN ADMISSION, SERVICE, OR PROCEDURE MUST BE REVIEWED OR DETERMINED IN ACCORDANCE WITH STANDARDS OR GUIDELINES 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

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

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

NEW SECTION. **Section 5. Presumption of medical necessity.** If a licensed physician certifies in writing to an insurer within 72 hours of an admission that the insured 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.

NEW SECTION. **Section 6. Appeal and assignment of claim.** (1) A patient or provider affected by an adverse

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

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

~~(3)--Notwithstanding--any--provision--to--the---contrary contained--in--a--contract--or-plan-for-health-care-benefits issued--after---July-1,---1991,---following---denial---after utilization-review-and-appeal-or-reconsideration-as-provided in--this--section,--a--claim-for-health-care-benefits-may-be assigned-to-the-health-care-provider-by-the-covered-person.~~

~~NEW-SECTION.--Section-7.--Persons-considered-engaged--in 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.~~

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

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

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

~~decisions-resulting-from-utilization-reviews;~~

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

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

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

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

NEW SECTION. **Section 9. Application of act -- exemptions.** (1) The provisions of [sections 1 through ~~10~~ 9] apply to a person or entity performing utilization reviews who is, or is affiliated with, under contract with, or acting on behalf of:

(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

fund, or preferred provider organization authorized to offer health insurance policies or contracts;

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

(iii) a state agency.

(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 ~~10~~ 9] as long as the review does not DIRECTLY result in the approval or denial of payment for health care services for a particular case.

NEW SECTION. **Section 10. Codification instruction.** [Sections 1 through ~~10~~ 9] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through ~~10~~ 9].

~~NEW-SECTION.--Section-12.--Effective-date.-[This-act]-is effective-July-1,-1991.~~

-End-

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

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
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
14 APPROPRIATENESS OF HEALTH CARE SERVICES RENDERED TO A
15 PATIENT; TO-PROVIDE-A-PRESUMPTION-OF--MEDICAL--NECESSITY--OF
16 HEALTH--CARE--SERVICES--IF--AN--INSURED-PERSON-IS-IN-NEED-OF
17 IMMEDIATE-ADMISSION-TO-A-HEALTH-CARE--FACILITY; 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-EFFECTIVE-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
25 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;
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 10 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 10 9] to:
25 (1) promote the delivery of quality health care in a

THIRD READING
AS AMENDED

cost-effective manner;

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

(3) ensure access to health care services; and

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

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through ~~10~~ 9] the following definitions apply:

(1) "Commissioner" means the commissioner of insurance 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 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; AND

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

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

(5) "UTILIZATION REVIEW AGENT" MEANS A PERSON OR ENTITY PERFORMING UTILIZATION REVIEW EXCEPT AN AGENCY OF THE FEDERAL GOVERNMENT OR AN AGENT ACTING ON BEHALF OF THE FEDERAL GOVERNMENT TO THE EXTENT THE AGENT IS PROVIDING SERVICES TO THE FEDERAL GOVERNMENT.

NEW SECTION. **Section 3. Utilization review plan.** A person may not conduct a utilization review of health care 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:

(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:

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

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

(c) ensure quality of care; and

(d) ensure access to needed health care services;

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

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

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

(5) policies and procedures to ensure compliance with

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

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

~~(7)--a--list--of--the--persons--or--entities-for-whom-the person-is-performing-utilization-reviews-in-this-state;-and~~

~~(8)~~(7) any other information as may be required by the commissioner that is necessary to implement [sections 1 through ~~10~~ 9].

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 affected--health-care-provider-may-not-be-made-on-a-question relating~~ BY A UTILIZATION REVIEW AGENT AS to the necessity or appropriateness ~~for-a-health-care-service-without-prior evaluation-and-concurrence-in-the-adverse--determination~~ OF AN ADMISSION, SERVICE, OR PROCEDURE MUST BE REVIEWED OR DETERMINED IN ACCORDANCE WITH STANDARDS OR GUIDELINES 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

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

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

~~NEW SECTION. Section 5. Presumption of medical necessity. If a licensed physician certifies in writing to an insurer within 72 hours of an admission that the insured 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.~~

NEW SECTION. **SECTION 5.** COMMISSIONER NOT TO APPROVE OR DISAPPROVE PLANS. NOTHING IN [SECTIONS 1 THROUGH 9] MAY BE

CONSTRUED AS AUTHORIZING THE COMMISSIONER TO APPROVE OR DISAPPROVE A UTILIZATION REVIEW PLAN REQUIRED IN [SECTION 3].

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

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

~~(3) Notwithstanding any provision to the contrary contained in a contract or plan for health care benefits issued after July 1, 1991, following denial after utilization review and appeal or reconsideration as provided in this section, a claim for health care benefits may be assigned to the health care provider by the covered person.~~

~~NEW SECTION. Section 7. Persons considered engaged in 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.~~

NEW SECTION. **Section 7.** **Commissioner to adopt rules.**

1 The commissioner ~~shall~~ MAY adopt rules for the
2 implementation of [sections 1 through ~~10~~ 9], including but
3 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
15 DUPLICATED by federal law or regulations as applied to any
16 specific health care service, then the provision of
17 [sections 1 through ~~10~~ 9] that is preempted OR DUPLICATED by
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 NEW SECTION. **Section 9. Application of act --**
22 **exemptions.** (1) The provisions of [sections 1 through ~~10~~ 9]
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:

1 (a) a Montana business entity; or
2 (b) a third party that provides or administers health
3 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.
12 (2) A general in-house utilization review for a health
13 care provider, INCLUDING AN IN-HOUSE UTILIZATION REVIEW THAT
14 IS CONDUCTED BY OR FOR A LONG-TERM CARE FACILITY AND THAT IS
15 REQUIRED BY MEDICARE OR MEDICAID REGULATIONS, is exempt from
16 the provisions of [sections 1 through ~~10~~ 9] as long as the
17 review does not DIRECTLY result in the approval or denial of
18 payment for health care services for a particular case.
19 NEW SECTION. **Section 10.** Codification instruction.
20 [Sections 1 through ~~10~~ 9] are intended to be codified as an
21 integral part of Title 33, and the provisions of Title 33
22 apply to [sections 1 through ~~10~~ 9].
23 ~~NEW-SECTION.--Section-12.--Effective-date.-[This-act]-is~~
24 ~~effective-July-1,-1991.~~

-End-

HOUSE STANDING COMMITTEE REPORT

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

Signed: Bob Bachini
Bob Bachini, 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]."

HOUSE
SB 394

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
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
11 PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF
12 UTILIZATION REVIEWS BY REQUIRING 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-EFFECTIVE-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
25 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;~~
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 ~~10~~ 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 ~~10~~ 9] to:
25 (1) promote the delivery of quality health care in a

REFERENCE BILL
AS AMENDED

cost-effective manner;

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

(3) ensure access to health care services; and

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(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; AND

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

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

~~(5)--"UTILIZATION-REVIEW-AGENT"-MEANS-A-PERSON-OR-ENTITY PERFORMING--UTILIZATION--REVIEW--EXCEPT--AN--AGENCY--OF--THE FEDERAL--GOVERNMENT--OR--AN--AGENT--ACTING--ON-BEHALF-OF-THE FEDERAL-GOVERNMENT-TO-THE--EXTENT--THE--AGENT--IS--PROVIDING SERVICES-TO-THE-FEDERAL-GOVERNMENT.~~

NEW SECTION. **Section 3.** Utilization review plan. A person may not conduct a utilization review of health care

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:

(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:

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

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

(c) ensure quality of care; and

(d) ensure access to needed health care services;

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

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

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

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

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

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

~~(7)--a--list--of--the--persons--or--entities--for--whom--the person-is-performing-utilization-reviews-in-this-state;-and~~

~~(8)~~(7) any other information as may be required by the commissioner that is necessary to implement [sections 1 through ~~10~~ 9].

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 affected--health-care-provider-may-not-be-made-on-a-question relating~~ ~~BY-A-UTILIZATION-REVIEW-AGENT-AS~~ 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 to the necessity or appropriateness ~~for--a--health--care--service without--prior--evaluation--and--concurrence--in-the-adverse~~

determination OF ~~AN-ADMISSION,-SERVICE,-OR-PROCEDURE-MUST-BE REVIEWED-OR--DETERMINED--IN--ACCORDANCE--WITH--STANDARDS--OR GUIDELINES--APPROVED~~ ~~by--a-physician.~~ 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.

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

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

~~as---the---case---may---be,~~ concerning the necessity or appropriateness of the health care service.

~~NEW-SECTION.--Section-5.--Presumption-----of-----medical necessity.--If-a-licensed-physician-certifies-in--writing--to an--insurer-within-72-hours-of-an-admission-that-the-insured 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.~~

NEW SECTION. **SECTION 5.** COMMISSIONER NOT TO APPROVE OR DISAPPROVE PLANS. NOTHING IN [SECTIONS 1 THROUGH 9] MAY BE CONSTRUED AS AUTHORIZING THE COMMISSIONER TO APPROVE OR DISAPPROVE A UTILIZATION REVIEW PLAN REQUIRED IN [SECTION 3].

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

(2) A final decision on appeal or reconsideration must be made within ~~30~~ 60 days of receipt of ~~the~~ ALL RELEVANT medical records by the person conducting the utilization

review ~~and--not-less-than-60-days-following-the-request-for appeal-or-reconsideration.~~

~~(3)--Notwithstanding--any--provision--to--the---contrary contained--in--a--contract--or-plan-for-health-care-benefits issued--after---July-1,---1991,---following---denial---after utilization-review-and-appeal-or-reconsideration-as-provided in--this--section,--a--claim-for-health-care-benefits-may-be assigned-to-the-health-care-provider-by-the-covered-person.~~

~~NEW-SECTION.--Section-7.--Persons-considered-engaged--in 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.~~

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

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

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

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

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

~~(5)~~(3) the protection of the confidentiality of medical

records used in the course of utilization reviews.

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

NEW SECTION. **Section 9. Application of act -- exemptions.** (1) The provisions of [sections 1 through ~~10~~ 9] apply to a person or entity performing utilization reviews who is, or is affiliated with, under contract with, or acting on behalf of:

(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 fund, or preferred provider organization authorized to offer health insurance policies or contracts;

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

(iii) a state agency.

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 10 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 10 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 10 9].
15 ~~NEW-SECTION.--Section-12.--Effective-date.--[This-act]-is~~
16 ~~effective-July-1,-1991.~~

-End-