State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3398

02/17/2020 Authored by Morrison, Hamilton, Albright, Mann, O'Neill and others
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health care coverage; modifying requirements governing utilization review and prior authorization of health care services; making conforming changes; amending Minnesota Statutes 2018, sections 62M.01, subdivision 2; 62M.02, subdivisions 2, 5, 8, 20, 21, by adding subdivisions; 62M.04, subdivisions 1, 2, 3, 4; 62M.05, subdivisions 3, 3a, 4, 5, by adding a subdivision; 62M.06, subdivisions 1, 3, 4; 62M.07; 62M.09, subdivisions 3, 3a, 4, 4a, 5; 62M.10, subdivision 7, by adding a subdivision; 62M.11; 62M.12; 62M.14; 62Q.71; 62Q.73, subdivision 1; 256B.0625, subdivision 25; proposing coding for new law in Minnesota Statutes, chapters 62A; 62M; repealing Minnesota Statutes 2018, sections 62D.12, subdivision 19; 62M.02, subdivision 19; 62M.05, subdivision 3b; 62M.06, subdivision 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

UTILIZATION REVIEW AND PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Section 1. **[62A.58] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

A health carrier may not deny or limit coverage of a service the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered by the health carrier under the enrollee's health plan had prior authorization or second opinion been obtained. For purposes of this section, "prior authorization" has the meaning given in section 62M.02, subdivision 15.

EFFECTIVE DATE. This section is effective August 1, 2020, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62M.01, subdivision 2, is amended to read:

Subd. 2. **Jurisdiction.** ~~Sections 62M.01 to 62M.16 apply~~ This chapter applies to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; the Minnesota Comprehensive Health Association created under chapter 62E; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; any other individual or entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits to individuals treated by a health professional under a policy, plan, or contract; or any entity performing utilization review on behalf of an employer with employees in this state who are covered under a health benefit plan, a health plan company, a preferred provider organization, or a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Sec. 3. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization to deny, reduce, or terminate coverage for an admission, extension of stay, or health care service furnished or proposed to be furnished to an enrollee on the ground that the admission, extension of stay, or health care service is not medically necessary, is unproven, or is experimental or investigational.

Sec. 4. Minnesota Statutes 2018, section 62M.02, subdivision 5, is amended to read:

Subd. 5. ~~**Certification**~~ **Authorization.** ~~"Certification"~~ "Authorization" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that ~~it~~, based on the information provided, ~~meets~~ it satisfies the utilization review organization's requirements ~~of the applicable health plan and the health plan company will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible,~~

~~co-payment, coinsurance, or other policy requirements have been met~~ for medical necessity and appropriateness and payment will be made for that admission, extension of stay, or health care service.

Sec. 5. Minnesota Statutes 2018, section 62M.02, subdivision 8, is amended to read:

Subd. 8. **Clinical criteria.** "Clinical criteria" means the coverage guidelines, written policies, ~~decision~~ written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, or ~~guidelines~~ any other criteria or rationale used by the utilization review organization to determine ~~certification~~ whether a health care service is medically necessary and appropriate.

Sec. 6. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 10a. **Emergency health care service.** "Emergency health care service" means a health care service necessary to treat a medical condition in which the absence of immediate medical attention could reasonably be expected to result in a condition described in United States Code, title 42, section 1395dd(e)(1)(A)(i), (ii), or (iii).

Sec. 7. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 12b. **Health care service.** "Health care service" means:

(1) a health care procedure, treatment, or service provided by a health care facility or a physician office;

(2) a health care procedure, treatment, or service provided by a doctor of medicine, doctor of osteopathy, or other health professional within the scope of practice for that professional; or

(3) the provision of pharmaceutical products or services, medical supplies, or durable medical equipment.

Sec. 8. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 13a. **Medically necessary.** "Medically necessary" means a health care service provided to an enrollee:

(1) for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or a symptom of an illness, injury, or disease; and

(2) in a manner that is:

(i) in accordance with generally accepted standards of medical practice;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(iii) not primarily for the economic benefit of the health plan company or sponsor of the health benefit plan, or for the convenience of the patient or treating health professional.

Sec. 9. Minnesota Statutes 2018, section 62M.02, subdivision 20, is amended to read:

Subd. 20. **Utilization review.** "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes prior authorization and review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance notification. Utilization review does not include a referral or participation in a referral process by a participating provider unless the provider is acting as a utilization review organization.

Sec. 10. Minnesota Statutes 2018, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **Utilization review organization.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a prepaid limited health service organization issued a certificate of authority and operating under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and ~~determines certification of~~ authorizes or makes adverse determinations regarding an admission, extension of stay, or other health care services for a Minnesota resident; any other individual or entity

that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits to individuals treated by a health professional under a policy, plan, or contract; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, an employer with employees in this state who are covered under a health benefit plan, a health plan company, a preferred provider organization, or a business entity in this state. Utilization review organization does not include a clinic or health care system acting pursuant to a written delegation agreement with an otherwise regulated utilization review organization that contracts with the clinic or health care system. The regulated utilization review organization is accountable for the delegated utilization review activities of the clinic or health care system.

Sec. 11. Minnesota Statutes 2018, section 62M.04, subdivision 4, is amended to read:

Subd. 4. **Additional information.** A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of agreement between the utilization review organization and the provider regarding the appropriateness of ~~certification~~ authorization during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

(1) tentatively determined through its professional staff that a service cannot be ~~certified~~ authorized;

(2) referred the case to a physician for review and a determination; and

(3) talked to or attempted to talk to the attending health care professional for further information.

Nothing in ~~sections 62M.01 to 62M.16~~ this chapter prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

Sec. 12. Minnesota Statutes 2018, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. ~~**Standard review**~~ **Determination.** (a) ~~Notwithstanding subdivision 3b, An initial~~ A determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ~~ten business days of~~ 36 hours after receiving the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

For purposes of this subdivision and subdivision 4, "information reasonably necessary to make a determination on the request" must include the results of any face-to-face clinical evaluation or a second opinion that may be required.

(b) When ~~an initial~~ a determination is made to ~~certify~~ authorize, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission ~~certified~~ authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates ~~certification~~ authorization by use of a number, the number must be called the "~~certification~~ authorization number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an ~~initial~~ adverse determination is made ~~not to certify~~, notification must be provided within 36 hours after receiving the request by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox ~~within one working day after making the determination~~ to the attending health care professional and hospital or physician office as applicable. Written notification must also be sent to the hospital or physician office as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include ~~the principal reason or~~ all reasons relied on by the utilization review organization for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for ~~a~~ an adverse determination ~~not to certify~~ may include, among other things, the lack of adequate information to ~~certify~~ authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an ~~initial~~ adverse determination is made ~~not to certify~~, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for

initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Sec. 13. Minnesota Statutes 2018, section 62M.05, subdivision 4, is amended to read:

Subd. 4. **Failure to provide necessary information.** A utilization review organization must have written procedures to address the failure of a provider or enrollee to provide the ~~necessary~~ information ~~for review~~ reasonably necessary to make a determination on the request. If the enrollee or provider will not release the necessary information to the utilization review organization, the utilization review organization may ~~deny certification~~ make an adverse determination in accordance with its own policy or the policy described in the health benefit plan.

Sec. 14. Minnesota Statutes 2018, section 62M.05, is amended by adding a subdivision to read:

Subd. 6. **Authorization; primary service in bundle of services.** If a utilization review organization authorizes the primary health care service in a bundle of services for which a bundled payment is charged, all other health care services included in that bundle of services are deemed to be authorized.

Sec. 15. Minnesota Statutes 2018, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **~~Standard~~ Appeal.** (a) The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within ~~30 days upon~~ 72 hours after receipt of the notice of appeal. If the utilization review organization cannot make a determination within ~~30 days~~ 72 hours due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to ~~14~~ 72 additional ~~days~~ hours to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial ~~30-day~~ 72-hour period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(c) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(d) Prior to upholding the ~~initial~~ adverse determination ~~not to certify~~ for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~initial~~ adverse determination ~~not to certify~~.

(e) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the ~~initial~~ determination is made.

(f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse ~~a~~ an adverse determination ~~not to certify~~ shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(g) In cases of appeal to reverse ~~a~~ an adverse determination ~~not to certify~~ for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(h) If the ~~initial~~ determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating an appeal under the external process.

Sec. 16. Minnesota Statutes 2018, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

Subdivision 1. **Written standards.** ~~(a)~~ Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, ~~subdivisions~~ subdivision 3a ~~and 3b~~, regarding time frames for ~~approving and disapproving~~ authorizing and making adverse determinations regarding prior authorization requests;

(4) written procedures ~~for appeals of denials~~ to appeal adverse determinations of prior authorization requests which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

Subd. 2. **Prior authorization of emergency services prohibited.** ~~(b)~~ No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or an emergency ~~treatment~~ health care service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency ~~treatment as reasonably possible~~ health care service.

Subd. 3. **Retrospective revocation or limitation of prior authorization.** No utilization review organization, health plan company, or claims administrator may revoke, limit, condition, or restrict a prior authorization that has been authorized unless there is evidence that the prior authorization was authorized based on fraud or misinformation.

Subd. 4. **Submission of prior authorization requests.** ~~(c)~~ If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through ~~an~~ the uniform electronic prior authorization form developed by the commissioner of health or another electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare or medical assistance.

EFFECTIVE DATE. Subdivision 4 is effective January 1, 2022.

Sec. 17. Minnesota Statutes 2018, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer ~~involvement~~; determinations.** (a) A physician must review and make the determination under section 62M.05 in all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for clinical reasons is appropriate.

(b) The physician conducting the review and making the determination must ~~be licensed~~:

(1) hold a current, unrestricted license to practice medicine in this state~~.~~;and

(2) have experience treating patients with the illness, injury, or disease for which the health care service has been requested.

This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

Sec. 18. Minnesota Statutes 2018, section 62M.10, subdivision 7, is amended to read:

Subd. 7. **Availability of criteria.** ~~Upon request,~~ (a) For utilization review determinations other than prior authorization a utilization review organization shall, upon request, provide to an enrollee, a provider, and the commissioner of commerce the criteria used to determine the medical necessity, appropriateness, and efficacy of a procedure or service and identify the database, professional treatment guideline, or other basis for the criteria.

(b) For prior authorization determinations, a utilization review organization must submit the organization's current prior authorization requirements and restrictions, including all written, evidence-based, clinical criteria used to make an authorization or adverse determination, to all health plan companies for which the organization performs utilization review. A health plan company must post on its public website the prior authorization requirements and restrictions of any utilization review organization that performs utilization review for the health plan company. These prior authorization requirements and restrictions must be detailed and written in easily understandable language.

Sec. 19. Minnesota Statutes 2018, section 62M.10, is amended by adding a subdivision to read:

Subd. 8. **Notice; new prior authorization requirements or restrictions; change to existing requirement or restriction.** (a) Before a utilization review organization may implement a new prior authorization requirement or restriction or amend an existing prior authorization requirement or restriction, the utilization review organization must submit the new or amended requirement or restriction to all health plan companies for which the organization performs utilization review and must ensure that the public websites of these health plan companies are updated with the new or amended requirement or restriction.

(b) At least 60 days before a utilization review organization implements a new prior authorization requirement or restriction or amends an existing prior authorization requirement or restriction, the utilization review organization must provide written notice of the new or amended requirement or restriction to all attending health care professionals who are subject to the utilization review organization's prior authorization requirements and restrictions.

Sec. 20. Minnesota Statutes 2018, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of ~~sections 62M.01 to 62M.16~~ this chapter, an enrollee or attending health care professional may file a complaint regarding ~~a~~ an adverse determination ~~not to certify~~ directly to the commissioner responsible for regulating the utilization review organization.

Sec. 21. Minnesota Statutes 2018, section 62M.14, is amended to read:

62M.14 EFFECT OF COMPLIANCE OR NONCOMPLIANCE.

If a utilization review organization or health plan company fails to comply with a requirement in this chapter for conducting utilization review of an inpatient admission, extension of stay, or health care service, that inpatient admission, extension of stay, or health care service is automatically deemed to be authorized. Evidence of a utilization review organization's compliance or noncompliance with the provisions of ~~sections 62M.01 to 62M.16~~ this chapter shall not be determinative in an action alleging that services denied were ~~medically necessary and~~ covered under the terms of the enrollee's health benefit plan.

Sec. 22. **[62M.17] CONTINUITY OF CARE; PRIOR AUTHORIZATIONS.**

Subdivision 1. **Compliance with prior authorization approved by previous utilization review organization; change in health plan company.** If an enrollee obtains coverage from a new health plan company and the health plan company for the enrollee's new health benefit plan uses a different utilization review organization from the enrollee's previous health benefit plan to conduct utilization review, the health plan company for the enrollee's new health benefit plan shall comply with a prior authorization for health care services approved by the utilization review organization used by the enrollee's previous health benefit plan for at least the first 60 days that the enrollee is covered under the new health benefit plan. In order to obtain coverage for this 60-day time period, the enrollee or the enrollee's attending health care professional must submit documentation of the previous prior authorization to the enrollee's new health plan company according to procedures in the enrollee's new health benefit plan. During this 60-day time period, the utilization review organization used by the enrollee's new health plan company may conduct its own utilization review of these health care services.

Subd. 2. **Compliance with prior authorization; change in health benefit plan.** If an enrollee enrolls in a new health benefit plan issued by the health plan company that also issued the enrollee's previous health benefit plan, the health plan company shall comply with any prior authorizations approved for the enrollee while covered under the previous health benefit plan.

Subd. 3. **Effect of change in prior authorization clinical criteria.** If, during a plan year, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, a utilization review organization shall not apply the change in coverage terms or change in clinical criteria until the next plan year for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

Sec. 23. **[62M.18] ANNUAL POSTING ON WEBSITE; PRIOR AUTHORIZATIONS.**

(a) By August 1, 2021, and each August 1 thereafter, a health plan company must post on the health plan company's public website, the following data for the immediately preceding July 1 to June 30 reporting period for each commercial product and medical assistance managed care product type:

(1) the number of prior authorization requests for which an authorization was issued; and

(2) the number of prior authorization requests for which an adverse determination was issued, broken out by health care service; by physician specialty type or type of attending health care professional seeking prior authorization; by whether the adverse determination was appealed; and by whether the adverse determination was upheld or reversed on appeal.

(b) All information posted under this section must be written in easily understandable language.

Sec. 24. Minnesota Statutes 2018, section 256B.0625, subdivision 25, is amended to read:

Subd. 25. **Prior authorization required.** (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's website a list of health services that require prior authorization, the criteria and standards used to select health services on the list, and the criteria and standards used to determine whether certain providers must obtain prior authorization for their services. The list of services requiring prior authorization and the criteria and standards used to formulate the list of services or the selection of providers for whom prior authorization is required are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service or is required for a provider is not subject to administrative appeal. Use of criteria or standards to select providers for whom prior authorization is required shall not impede access to the service involved for any group of individuals with unique or special needs due to disability or functional condition.

(b) The commissioner shall implement a modernized electronic system for providers to request prior authorization. The modernized electronic system must include at least the following functionalities:

(1) authorizations are recipient-centric, not provider-centric;

(2) adequate flexibility to support authorizations for an episode of care, continuous drug therapy, or for individual onetime services and allows an ordering and a rendering provider to both submit information into one request;

(3) allows providers to review previous authorization requests and determine where a submitted request is within the authorization process;

(4) supports automated workflows that allow providers to securely submit medical information that can be accessed by medical and pharmacy review vendors as well as department staff; and

(5) supports development of automated clinical algorithms that can verify information and provide responses in real time.

(c) The system described in paragraph (b) shall be completed by March 1, 2012. All authorization requests submitted on and after March 1, 2012, or upon completion of the modernized authorization system, whichever is later, must be submitted electronically by providers, except requests for drugs dispensed by an outpatient pharmacy, services that are provided outside of the state and surrounding local trade area, and services included on a service agreement.

(d) The commissioner shall comply with the requirements for prior authorization in chapter 62M, when implementing prior authorization under this chapter.

Sec. 25. **DEVELOPMENT OF ELECTRONIC PRIOR AUTHORIZATION FORM.**

(a) The commissioner of health shall develop a uniform electronic prior authorization form for use by utilization review organizations and attending health care professionals. In developing the form, the commissioner shall:

(1) obtain input from interested parties, including psychiatrists, physicians, health plan companies, and utilization review organizations; and

(2) take into consideration existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services or the commissioner, and national standards relating to electronic prior authorization.

(b) The uniform electronic prior authorization form required by this section must be developed and available for use by utilization review organizations and attending health care professionals by January 1, 2022.

Sec. 26. **SEVERABILITY.**

If any provision of this act is held invalid, illegal, or unenforceable, the remaining provisions of this act are valid.

Sec. 27. **REPEALER.**

Minnesota Statutes 2018, sections 62D.12, subdivision 19; 62M.02, subdivision 19; 62M.05, subdivision 3b; and 62M.06, subdivision 2, are repealed.

ARTICLE 2
CONFORMING CHANGES

Section 1. Minnesota Statutes 2018, section 62M.02, subdivision 2, is amended to read:

Subd. 2. **Appeal.** "Appeal" means a formal request, either orally or in writing, to reconsider ~~a~~ an adverse determination ~~not to certify~~ regarding an admission, extension of stay, or other health care service.

Sec. 2. Minnesota Statutes 2018, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. **Responsibility for obtaining ~~certification~~ authorization.** A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining ~~certification~~ authorization for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain ~~certification~~ authorization for health care services.

Sec. 3. Minnesota Statutes 2018, section 62M.04, subdivision 2, is amended to read:

Subd. 2. **Information upon which utilization review is conducted.** (a) If the utilization review organization is conducting routine prospective and concurrent utilization review, utilization review organizations must collect only the information necessary to ~~certify~~ authorize the admission, procedure of treatment, and length of stay.

(b) Utilization review organizations may request, but may not require providers to supply, numerically encoded diagnoses or procedures as part of the ~~certification~~ authorization process.

(c) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in ~~certifying~~ authorizing the medical necessity or appropriateness of the admission or extension of stay.

(d) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization review organization for retrospective review unless otherwise provided under the terms of the provider contract.

Sec. 4. Minnesota Statutes 2018, section 62M.04, subdivision 3, is amended to read:

Subd. 3. **Data elements.** (a) Except as otherwise provided in ~~sections 62M.01 to 62M.16~~ this chapter, for purposes of ~~certification~~ authorization a utilization review organization must limit its data requirements to the following elements:

(b) Patient information that includes the following:

(1) name;

(2) address;

(3) date of birth;

(4) sex;

(5) Social Security number or patient identification number;

(6) name of health plan company or health plan; and

(7) plan identification number.

(c) Enrollee information that includes the following:

(1) name;

(2) address;

(3) Social Security number or employee identification number;

(4) relation to patient;

(5) employer;

(6) health benefit plan;

(7) group number or plan identification number; and

(8) availability of other coverage.

(d) Attending health care professional information that includes the following:

(1) name;

(2) address;

(3) telephone numbers;

(4) degree and license;

(5) specialty or board certification status; and

(6) tax identification number or other identification number.

(e) Diagnosis and treatment information that includes the following:

(1) primary diagnosis with associated ICD or DSM coding, if available;

(2) secondary diagnosis with associated ICD or DSM coding, if available;

(3) tertiary diagnoses with associated ICD or DSM coding, if available;

(4) proposed procedures or treatments with ICD or associated CPT codes, if available;

(5) surgical assistant requirement;

(6) anesthesia requirement;

(7) proposed admission or service dates;

(8) proposed procedure date; and

(9) proposed length of stay.

(f) Clinical information that includes the following:

(1) support and documentation of appropriateness and level of service proposed; and

(2) identification of contact person for detailed clinical information.

(g) Facility information that includes the following:

(1) type;

(2) licensure and certification status and DRG exempt status;

(3) name;

(4) address;

(5) telephone number; and

(6) tax identification number or other identification number.

(h) Concurrent or continued stay review information that includes the following:

(1) additional days, services, or procedures proposed;

(2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and

(3) diagnosis status.

(i) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:

(1) history of present illness;

(2) patient treatment plan and goals;

(3) prognosis;

(4) staff qualifications; and

(5) 24-hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

Sec. 5. Minnesota Statutes 2018, section 62M.05, subdivision 3, is amended to read:

Subd. 3. **Notification of adverse determinations and authorizations.** A utilization review organization must have written procedures for providing notification of ~~its determinations on~~ all ~~certifications~~ of its adverse determinations and authorizations in accordance with this section.

Sec. 6. Minnesota Statutes 2018, section 62M.05, subdivision 5, is amended to read:

Subd. 5. **Notification to claims administrator.** If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of ~~certification or determination not to certify~~ an authorization or adverse determination to the appropriate claims administrator for the health benefit plan. If it is determined by the claims administrator that the ~~certified~~ authorized health care service is not covered by the health benefit plan, the claims administrator must promptly notify the claimant and provider of this information.

Sec. 7. Minnesota Statutes 2018, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of adverse determinations ~~not to certify~~. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69, 256B.692, or chapter 256L, or to grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

Sec. 8. Minnesota Statutes 2018, section 62M.06, subdivision 4, is amended to read:

Subd. 4. **Notification to claims administrator.** If the utilization review organization and the claims administrator are separate entities, the utilization review organization must notify, either electronically or in writing, the appropriate claims administrator for the health benefit plan of any adverse determination ~~not to certify~~ that is reversed on appeal.

Sec. 9. Minnesota Statutes 2018, section 62M.09, subdivision 3a, is amended to read:

Subd. 3a. **Mental health and substance abuse reviews.** (a) A peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review requests for outpatient services in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a mental health or substance abuse service for clinical reasons is appropriate, provided that any final adverse determination ~~not to certify~~ issued under section 62M.05 for a treatment is made by a psychiatrist certified by the American Board of Psychiatry and Neurology and appropriately licensed in this state or by a doctoral-level psychologist licensed in this state.

(b) Notwithstanding paragraph (a), a doctoral-level psychologist shall not review any request or final adverse determination ~~not to certify~~ for a mental health or substance abuse service or treatment if the treating provider is a psychiatrist.

(c) Notwithstanding the notification requirements of section 62M.05, a utilization review organization that has made ~~an initial decision~~ a determination to ~~certify~~ authorize in

accordance with the requirements of section 62M.05 may elect to provide notification of a determination to continue coverage through facsimile or mail.

(d) This subdivision does not apply to determinations made in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

Sec. 10. Minnesota Statutes 2018, section 62M.09, subdivision 4, is amended to read:

Subd. 4. **Dentist plan reviews.** A dentist must review all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a dental service or procedure for clinical reasons is appropriate and an appeal has been made by the attending dentist, enrollee, or designee.

Sec. 11. Minnesota Statutes 2018, section 62M.09, subdivision 4a, is amended to read:

Subd. 4a. **Chiropractic review.** A chiropractor must review all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee.

Sec. 12. Minnesota Statutes 2018, section 62M.09, subdivision 5, is amended to read:

Subd. 5. **Written clinical criteria.** A utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the ~~certification~~ authorization request. The utilization review organization must have a procedure for ensuring, at a minimum, the annual evaluation and updating of the written criteria based on sound clinical principles.

Sec. 13. Minnesota Statutes 2018, section 62M.12, is amended to read:

62M.12 PROHIBITION OF INAPPROPRIATE INCENTIVES.

No individual who is performing utilization review may receive any financial incentive based on the number of ~~denials of certifications~~ adverse determinations made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health plan companies and providers.

Sec. 14. Minnesota Statutes 2018, section 62Q.71, is amended to read:

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain ~~certification~~ authorization for health care services;

(3) how to request an appeal either through the procedures described in section 62Q.70, if applicable, or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the appropriate commissioner; and

(6) of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

(i) the health plan company waives the exhaustion requirement;

(ii) the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or

(iii) the enrollee has applied for an expedited external review at the same time the enrollee ~~qualifies for and~~ has applied for ~~an expedited~~ internal review under chapter 62M.

Sec. 15. Minnesota Statutes 2018, section 62Q.73, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(4) any ~~initial~~ adverse determination ~~not to certify~~, as defined in section 62M.02, subdivision 1a, that has been appealed in accordance with section 62M.06 and the appeal did not reverse the ~~initial~~ adverse determination ~~not to certify~~;

(5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary; or

(6) the enrollee has met the requirements of subdivision 6, paragraph (e).

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Sec. 16. **REVISOR INSTRUCTIONS.**

(a) In Minnesota Statutes, chapter 62M, the revisor of statutes shall replace references to "sections 62M.01 to 62M.16" with "this chapter." In Minnesota Statutes, section 256B.692, subdivision 2, the revisor of statutes shall replace a reference to "sections 62M.01 to 62M.16" with "chapter 62M." The revisor shall make any necessary technical and conforming changes to sentence structure to preserve the meaning of the text.

(b) The revisor of statutes shall replace the term "DETERMINATIONS NOT TO CERTIFY" with "ADVERSE DETERMINATIONS" in the section headnote for Minnesota Statutes, section 62M.06.

62D.12 PROHIBITED PRACTICES.

Subd. 19. **Coverage of service.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained.

62M.02 DEFINITIONS.

Subd. 19. **Reconsideration request.** "Reconsideration request" means an initial request by telephone for additional review of a utilization review organization's determination not to certify an admission, extension of stay, or other health care service.

62M.05 PROCEDURES FOR REVIEW DETERMINATION.

Subd. 3b. **Expedited review determination.** (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

62M.06 APPEALS OF DETERMINATIONS NOT TO CERTIFY.

Subd. 2. **Expedited appeal.** (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.