CHAPTER 62M

UTILIZATION REVIEW OF HEALTH CARE

62M.01 CITATION, JURISDICTION, AND SCOPE.

Subdivision 1. **Popular name.** Sections 62M.01 to 62M.16 may be cited as the "Minnesota Utilization Review Act of 1992."

Subd. 2. **Jurisdiction.** Sections 62M.01 to 62M.16 apply 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; 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; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. **Scope.** Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

History: *1999 c 239 s 3*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 3, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.02 DEFINITIONS.

[For text of subds 1 and 2, see M.S.1998]

Subd. 3. **Attending dentist.** "Attending dentist" means the dentist with primary responsibility for the dental care provided to an enrollee.

Subd. 4. **Attending health care professional.** "Attending health care professional" means the health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to an enrollee. Attending health care professional shall include only physicians; chiropractors; dentists; mental health professionals as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; podiatrists; and advanced practice nurses.

Subd. 5. **Certification.** "Certification" 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 the utilization review 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, copayment, coinsurance, or other policy requirements have been met.

Subd. 6. **Claims administrator.** "Claims administrator" means an entity that reviews and determines whether to pay claims to enrollees or providers based on the contract provi-

sions of the health plan contract. Claims administrators may include insurance companies 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; 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 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.

Subd. 7. **Claimant.** "Claimant" means the enrollee who files a claim for benefits or a provider of services who, pursuant to a contract with a claims administrator, files a claim on behalf of an enrollee or covered person.

[For text of subd 8, see M.S.1998]

Subd. 9. **Concurrent review.** "Concurrent review" means utilization review conducted during an enrollee's hospital stay or course of treatment and has the same meaning as continued stay review.

Subd. 10. **Discharge planning.** "Discharge planning" means the process that assesses an enrollee's need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

Subd. 11. **Enrollee.** "Enrollee" means an individual covered by a health benefit plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, or hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Subd. 12a. **Health plan company.** "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and includes an accountable provider network operating under chapter 62T.

[For text of subds 13 to 16, see M.S.1998]

Subd. 17. **Provider.** "Provider" means a licensed health care facility, physician, or other health care professional that delivers health care services to an enrollee.

[For text of subds 18 and 19, see M.S.1998]

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 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.

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

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 an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

History: *1999 c 239 s 4–16*

NOTE: The amendments to subdivisions 3, 4, 5, 6, 7, 9, 10, 11, 12, 17, 20 and 21 by Laws 1999, chapter 239, sections 4 to 12 and 14 to 16, are effective April 1, 2000, and apply to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

NOTE: Subdivision 12a, as added by Laws 1999, chapter 239, section 13, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.03 COMPLIANCE WITH STANDARDS.

Subdivision 1. **Licensed utilization review organization.** Beginning January 1, 1993, any organization that meets the definition of utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a, for any services provided by providers under contract.

[For text of subd 2, see M.S.1998]

Subd. 3. **Penalties and enforcements.** If a utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

History: *1999 c 239 s 17,18*

NOTE: The amendments to subdivisions 1 and 3 by Laws 1999, chapter 239, sections 17 and 18, are effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.04 STANDARDS FOR UTILIZATION REVIEW PERFORMANCE.

Subdivision 1. **Responsibility for obtaining certification.** 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 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 for health care services.

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

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

(b) 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 the medical necessity or appropriateness of the admission or extension of stay.

(c) 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.

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

(a) 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

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 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;

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

[For text of subd 5, see M.S.1998]

History: *1999 c 239 s 19–22*

NOTE: The amendments to subdivisions 1, 2, 3, and 4 by Laws 1999, chapter 239, sections 19 to 22, are effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.05 PROCEDURES FOR REVIEW DETERMINATION.

Subdivision 1. **Written procedures.** A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter.

Subd. 2. **Concurrent review.** A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

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

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial 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 the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, 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; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

(c) When an initial determination is made not to certify, notification must be provided by telephone within one working day after making the determination to the attending health care professional and hospital and a written notification must be sent to the hospital, attending health care professional, and enrollee. The written notification must include the principal reason or reasons 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 determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an initial 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.

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.

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. If the enrollee or provider will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan.

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 to the appropriate claims administrator for the health benefit plan.

History: *1999 c 239 s 23*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 23, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.06 APPEALS OF DETERMINATIONS NOT TO CERTIFY.

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

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.

Subd. 3. **Standard appeal.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) 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 receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days 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 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.

(b) 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.

(c) Prior to upholding the initial 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 determination not to certify.

(d) 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.

(e) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a 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.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending health care professional, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) 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 the external process.

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 determination not to certify that is reversed on appeal.

History: *1999 c 239 s 24*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 24, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(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 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization 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.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. 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 after the beginning of the emergency confinement or emergency treatment as reasonably possible.

History: *1999 c 239 s 25*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 25, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.09 STAFF AND PROGRAM QUALIFICATIONS.

[For text of subds 1 and 2, see M.S.1998]

Subd. 3. **Physician reviewer involvement.** A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clini-

cal reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending health care professional. This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

[For text of subds 3a to 8, see M.S.1998]

History: *1999 c 239 s 26*

NOTE: The amendment to subdivision 3 by Laws 1999, chapter 239, section 26, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.10 ACCESSIBILITY AND ON-SITE REVIEW PROCEDURES.

[For text of subd 1, see M.S.1998]

Subd. 2. **Reviews during normal business hours.** A utilization review organization must conduct its telephone reviews, on-site reviews, and hospital communications during reasonable and normal business hours, unless otherwise mutually agreed.

[For text of subds 3 and 4, see M.S.1998]

Subd. 5. **Oral requests for information.** Utilization review organizations shall orally inform, upon request, designated hospital personnel or the attending health care professional of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. Utilization review organizations should also orally inform, upon request, a provider of the operational procedures in order to facilitate the review process.

[For text of subd 6, see M.S.1998]

Subd. 7. **Availability of criteria.** Upon request, a utilization review organization shall provide to an enrollee or to a provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

History: *1999 c 239 s 27–29*

NOTE: The amendments to subdivisions 2, 5, and 7 by Laws 1999, chapter 239, sections 27 to 29, are effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

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 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.

History: *1999 c 239 s 30*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 30, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

62M.15 APPLICABILITY OF OTHER CHAPTER REQUIREMENTS.

The requirements of this chapter regarding the conduct of utilization review are in addition to any specific requirements contained in chapter 62A, 62C, 62D, 62Q, 62T, or 72A.

History: *1999 c 239 s 31*

NOTE: The amendment to this section by Laws 1999, chapter 239, section 31, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c) by April 1, 2000, due to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.