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, subdivi sion 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 *1992 c 574 s 1, 1999 c 239 s 3*

62M 02 DEFINITIONS

Subdivision 1 **Terms** For the purposes of sections 62M 01 to 62M 16, the terms defined in this section have the meanings given them

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

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, subdivi-sion 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 provisions 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

Subd 8 **Clinical criteria** "Clinical criteria" means the written policies, decision rules, medical protocols, or guidelines used by the utilization review organization to determine certification

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

Subd 13 **Inpatient admissions to hospitals** "Inpatient admissions to hospitals" includes admissions to all acute medical, surgical, obstetrical, psychiatric, and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities including skilled nursing facilities, residential treatment centers, and free standing rehabilitation facilities

Subd 14 **Outpatient services** "Outpatient services" means procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, and chiropractic services

Subd 15 **Prior authorization** "Prior authorization" means utilization review conducted prior to the delivery of a service, including an outpatient service

Subd 16 **Prospective review** "Prospective review" means utilization review conducted prior to an enrollee's inpatient stay

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

Subd 18 **Quality assessment program** "Quality assessment program" means a structured mechanism that monitors and evaluates a utilization review organization's program and provides management intervention to support compliance with the requirements of this chapter

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

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 *1992 c 574 s 2, 1994 c 625 art 2 s 7,8, 1997 c 225 art 2 s 30, 1999 c 239 s 4-16*

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

Subd 2 **Nonlicensed utilization review organization** An organization that meets the definition of a utilization review organization under section 62M 02, subdivision 21, that is not licensed in this state that performs utilization review services for Minnesota residents must register with the commissioner of commerce and must certify compliance with sections 62M 01 to 62M 16

Initial registration must occur no later than January 1, 1993 The registration is effective for two years and may be renewed for another two years by written request Each utilization review organization registered under this chapter shall notify the commissioner of commerce within 30 days of any change in the name, address, or ownership of the organization

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 *1992 c 574 s 3, 1994 c 625 art 2 s 9-11, 1997 c 225 art 2 s 62, 1999 c 239 s 17,18*

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

Subd 5 **Sharing of information** To the extent allowed under sections 72A 49 to 72A 505, a utilization review orgamzation shall share all available clinical and demographic information on individual patients internally to avoid duplicate requests for information from enrollees or providers

History *1992 c 574 s 4, 1999 c 239 s 19 22*

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 orgamzation 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 orgamzation 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 *1992 c 574 s 5, 1994 c 485 s 65, 1994 c 625 art 2 s 12, 1999 c 239 s 23*

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 durmg 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 determmation 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 determmation not to certify is not reversed through the expedited appeal, the utilization review organization must mclude 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 writmg or by telephone

(a) A utilization review organization shall notify in writmg the enrollee, attending health care professional, and claims administrator of its determination on the appeal withm 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 admmistrator of its determination If the utilization review organization takes any additional days beyond the initial 30 day period to make its determmation, 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 mclude 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 determmation 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 mclude 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 determnation 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 determmation 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 *1992 c 574 s 6, 1994 c 625 art 2 s 13, 1999 c 239 s 24*

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 *1992 c 574 s 7, 1994 c 485 s 65, 1995 c 234 art 8 s 12, 1999 c 239 s 25*

62M 08 CONFIDENTIALITY

Subdivision 1 **Written procedures to ensure confidentiality** A utilization review organization must have written procedures for ensuring that patient specific information obtained during the process of utilization review will be

(1) kept confidential in accordance with applicable federal and state laws,

(2) used solely for the purposes of utilization review, quality assurance, discharge planning, and case management, and

(3) shared only with those organizations or persons that have the authority to receive such information

Subd 2 **Summary data** Summary data is not subject to this section if it does not provide sufficient information to allow identification of individual patients

History *1992 c 574 s 8*

62M 09 STAFF AND PROGRAM QUALIFICATIONS

Subdivision 1 **Staff criteria** A utilization review organization shall have utilization review staff who are properly trained, qualified, and supervised

Subd 2 **Licensure requirement** Nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty must be currently licensed or certified by an approved state licensing agency in the United States

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 clinical 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

Subd 3a **Mental health and substance abuse reviews** A peer of the treating mental health or substance abuse provider or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate, provided that any final determination not to certify treatment is made by a psychiatrist certified by the American Board of Psychiatry and Neurology and appropriately licensed in the state in which the psychiatrist resides Notwithstanding the notification requirements of section 62M 05, a utilization review organization that has made an initial decision to certify in accordance with the requirements of section 62M 05 may elect to provide notification of a determination to continue coverage through facsimile or mail

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

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

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 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

Subd 6 **Physician consultants** A utilization review organization must use physician consultants in the appeal process described in section 62M 06, subdivision 3 The physician consultants should include, as needed and available, specialists who are board certified, or board-eligible and working towards certification, in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy

Subd 7 **Training for program staff** A utilization review organization must have a formalized program of orientation and ongoing training of utilization review staff

Subd 8 **Quality assessment program** A utilization review organization must have written documentation of an active quality assessment program

History *1992 c 574 s 9, 1993 c 99 s 1, 1995 c 234 art 8 s 13, 1996 c 305 art 1 s 24, 1997 c 140 s 1,2, 1999 c 239 s 26*

62M 10 ACCESSIBILITY AND ON SITE REVIEW PROCEDURES

Subdivision 1 **Toll free number** A utilization review organization must provide access to its review staff by a toll-free or collect call telephone line during normal business hours A utilization review organization must also have an established procedure to receive timely callbacks from providers and must establish written procedures for receiving after-hour calls, either in person or by recording

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

Subd 3 **Identification of on-site review staff** Each utilization review organization's staff must identify themselves by name and by the name of their organization and, for on site reviews, must carry picture identification and the utilization review organization's company identification card On site reviews should, whenever possible, be

scheduled at least one business day in advance with the appropriate hospital contact If requested by a hospital or inpatient facility, utilization review organizations must ensure that their on-site review staff register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from hospital staff The on-site review staff must wear appropriate hospital supplied identification tags while on the premises

Subd 4 **On site reviews** Utilization review organizations must agree, if requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures must be followed by on-site review staff so as to not disrupt hospital operations or patient care Such procedures, however, must not limit the ability of the utilization review organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan

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

Subd 6 **Mutual agreement** Nothing in this section limits the ability of a utilization review organization and a provider to mutually agree in writing on how review should be conducted

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 *1992 c 574 s 10, 1995 c 234 art 8 s 14, 1999 c 239 s 27 29*

62M 11 COMPLAINTS TO COMMERCE OR HEALTH

Notwithstanding the provisions of sections 62M 01 to 62M 16, an enrollee may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization

History *1992 c 574 s 11*

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 *1992 c 574 s 12, 1999 c 239 s 30*

62M 13 SEVERABILITY

If any provisions of sections 62M 01 to 62M 16 are held invalid, illegal, or unenforceable for any reason and in any respect, the holding does not affect the validity of the remainder of sections 62M 01 to 62M 16

History *1992 c 574 s 13*

62M 14 EFFECT OF COMPLIANCE

Evidence of a utilization review organization's compliance or noncompliance with the provisions of sections 62M 01 to 62M 16 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

History *1992 c 574 s 14*

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 *1992 c 574 s 15, 1999 c 239 s 31*

62M 16 RULEMAKING

If it is determined that rules are reasonable and necessary to accomplish the purpose of sections 62M 01 to 62M 16, the rules must be adopted through a joint rulemaking process by both the department of commerce and the department of health

History *1992 c 574 s 16*