62M.09 STAFF AND PROGRAM QUALIFICATIONS; ANNUAL REPORT.

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) 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.

(b) The physician conducting the review must be licensed in this state. 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.

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 this state. 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. 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.

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 must be board certified 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.

Subd. 9. **Annual report.** A utilization review organization shall file an annual report with the annual financial statement it submits to the commissioner of commerce that includes:

(1) per 1,000 utilization reviews, the number and rate of determinations not to certify based on medical necessity for each procedure or service; and

(2) the number and rate of denials overturned on appeal.

A utilization review organization that is not a licensed health carrier must submit the annual report required by this subdivision on April 1 of each year.

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; 2001 c 137 s 2-5; 2006 c 255 s 33*