62M.07 PRIOR AUTHORIZATION OF SERVICES.

Subdivision 1. **Written standards.** 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 authorizing and making adverse determinations regarding prior authorization requests;

(4) written procedures 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.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or an emergency 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 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 or a previously approved prior authorization conflicts with state or federal law. Application of a deductible, coinsurance, or other cost-sharing requirement does not constitute a limit, condition, or restriction under this subdivision.

Subd. 4. **Submission of prior authorization requests.** 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 electronic mechanism 24 hours a day, seven days a week. This subdivision does not apply to dental service covered under MinnesotaCare or medical assistance.

History: *1992 c 574 s 7; 1994 c 485 s 65; 1995 c 234 art 8 s 12; 1999 c 239 s 25; 2004 c 246 s 1; 2016 c 158 art 2 s 22; 2020 c 114 art 1 s 15*