# CHAPTER 62M

# UTILIZATION REVIEW OF HEALTH CARE


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## 62M.01 CITATION, JURISDICTION, AND SCOPE.

Subdivision 1. **Popular name.** This chapter may be cited as the "Minnesota Utilization Review Act of 1992."

Subd. 2. **Jurisdiction.** 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 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 a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. **Scope.** (a) Nothing in this chapter 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.

(b) Effective January 1, 2026, this chapter applies to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

(c) Effective January 1, 2026, the following sections of this chapter apply to services delivered under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05,

subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

**History:** *1992 c 574 s 1; 1999 c 239 s 3; 2006 c 255 s 31; 2020 c 114 art 1 s 1,2; art 2 s 20; 2024 c 127 art 55 s 1*

**62M.02 DEFINITIONS.**

Subdivision 1. **Terms.** For the purposes of this chapter, the terms defined in this section have the meanings given them.

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including:

(1) a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary; or

(2) an authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

Subd. 2. **Appeal.** "Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination regarding 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, subdivision 27; podiatrists; and advanced practice registered nurses.

Subd. 5. **Authorization.** "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, based on the information provided, it satisfies the utilization review requirements of the applicable health benefit plan and the health plan company or commissioner 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.

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, rules, clinical protocols, medical protocols, or any other criteria or rationale used by the utilization review organization to determine whether a health care service is authorized.

Subd. 8a. **Commissioner.** "Commissioner" means, effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services, unless otherwise specified.

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. 10a. **Emergency services.** "Emergency services" has the meaning given in section 62Q.55, subdivision 3.

Subd. 11. **Enrollee.** "Enrollee" means:

(1) an individual covered by a health benefit plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder; or

(2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), a recipient receiving coverage through fee-for-service under chapters 256B and 256L.

Subd. 12. **Health benefit plan.** (a) "Health benefit plan" means:

(1) a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, or hospital benefits; or

(2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision 3, paragraph (c), coverage of medical, dental, or hospital benefits through fee-for-service under chapters 256B and 256L, as specified by the commissioner on the agency's public website or through other forms of recipient and provider guidance.

(b) 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 freestanding rehabilitation facilities.

Subd. 13a. **Medically necessary care.** "Medically necessary care" has the meaning given in section 62Q.53.

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. MS 2018 [Repealed, 2020 c 114 art 1 s 22]

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.

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 authorizes or makes adverse determinations regarding an admission, extension of stay, or other health care services for a Minnesota resident; effective January 1, 2026, for the sections specified in section 62M.01,

subdivision 3, paragraph (c), the commissioner of human services for purposes of delivering services through fee-for-service under chapters 256B and 256L; any other 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, 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.

**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; 1Sp2001 c 9 art 16 s 5; 2002 c 379 art 1 s 113; 2008 c 344 s 15; 2020 c 114 art 1 s 3-9; art 2 s 1,20; 2023 c 25 s 8; 2024 c 127 art 57 s 17-22*

## 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 this chapter 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 this chapter 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 this chapter.

Initial registration must occur no later than January 1, 1993. The registration is effective for two years and may be renewed. Applications for initial and renewal registrations must be made on forms prescribed by the commissioner. 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. The organization shall pay to the commissioner of commerce a fee of $1,000 for the initial registration application and $1,000 for each two-year renewal.

Subd. 3. **Penalties and enforcements.** If a utilization review organization fails to comply with this chapter, 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 this chapter 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 this chapter 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; 2001 c 215 s 24; 2002 c 330 s 27; 2020 c 114 art 2 s 20*

## 62M.04 STANDARDS FOR UTILIZATION REVIEW PERFORMANCE.

Subdivision 1. **Responsibility for obtaining 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 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. Effective January 1, 2026, the commissioner must provide a clear and concise description of this process to fee-for-service recipients receiving services under chapters 256B and 256L, through the agency's public website or through other forms of recipient guidance. 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 benefit 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 authorization for health care services.

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 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 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 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.

Subd. 3. **Data elements.** (a) Except as otherwise provided in this chapter, for purposes of 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.

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 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 authorized;

(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 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.

Subd. 5. **Sharing of information.** To the extent allowed under sections 72A.49 to 72A.505, a utilization review organization 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; 2020 c 114 art 2 s 2-5; 2024 c 127 art 57 s 23*

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

Subd. 3a. **Standard review determination.** (a) A standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When a determination is made to 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 authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates authorization by use of a number, the number must be called the "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 adverse determination is made, notification must be provided within the time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox 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 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 an adverse determination may include, among other things, the lack of adequate information to authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an adverse determination is made, 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.

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

(b) Notification of an expedited determination to authorize or an expedited adverse determination 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 48 hours and must include at least one business day after the initial request. When an expedited adverse determination is made, 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 expedited internal 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 information 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 make an adverse determination 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 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 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.

**History:** *1992 c 574 s 5; 1994 c 485 s 65; 1994 c 625 art 2 s 12; 1999 c 239 s 23; 2001 c 215 s 25; 2009 c 178 art 1 s 32; 2013 c 84 art 1 s 58; 2020 c 114 art 1 s 10-12; art 2 s 6,7; 2024 c 127 art 57 s 24*

## 62M.06 APPEALS OF ADVERSE DETERMINATIONS.

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of adverse determinations. 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 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).

Subd. 2. **Expedited appeal.** (a) When an adverse determination for 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 adverse determination 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.** (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 15 days after receipt of the notice of appeal. If the utilization review organization cannot make a determination within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to four 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 15-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.

(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 adverse determination for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the adverse determination.

(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 adverse determination is made.

(f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse an adverse determination 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 an adverse determination 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 adverse 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.

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 that is reversed on appeal.

**History:** *1992 c 574 s 6; 1994 c 625 art 2 s 13; 1999 c 239 s 24; 2001 c 137 s 1; 2013 c 84 art 1 s 59; 2020 c 114 art 1 s 13,14; art 2 s 8-10*

**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 certain services prohibited.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of:

(1) 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;

(2) outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is a medication. Prior authorizations required for medications used for outpatient mental health treatment or outpatient substance use disorder treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(3) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is a medication. Prior authorizations required for medications used for antineoplastic cancer treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(4) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

(5) pediatric hospice services provided by a hospice provider licensed under sections 144A.75 to 144A.755; and

(6) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.

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.** (a) 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.

(b) Effective January 1, 2027, for health benefit plans offered, sold, issued, or renewed on or after that date, utilization review organizations, health plan companies, and claims administrators must have and maintain a prior authorization application programming interface (API) that automates the prior authorization process for health care services, excluding prescription drugs and medications. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems. The API must use the Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations, title 45, section 170.215 (a)(1), and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement that section. Prior authorization submission requests for prescription drugs and medications must comply with the requirements of section 62J.497.

Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1, 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that date. An authorization for treatment of a chronic health condition does not expire unless the standard of treatment for that health condition changes. A chronic health condition is a condition that is expected to last one year or more and:

(1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or

(2) limits one or more activities of daily living.

**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; 2024 c 127 art 57 s 25-27*

**62M.072 USE OF EVIDENCE-BASED STANDARDS.**

If no independently developed evidence-based standards exist for a particular treatment, testing, or imaging procedure, then an insurer or utilization review organization shall not deny coverage of the treatment, testing, or imaging based solely on the grounds that the treatment, testing, or imaging does not meet an

evidence-based standard. This section does not prohibit an insurer or utilization review organization from denying coverage for services that are investigational, experimental, or not medically necessary.

**History:** *2006 c 255 s 32*

**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; adverse determinations.** (a) A physician must review and make the adverse determination under section 62M.05 in all cases in which the utilization review organization has concluded that an adverse determination for clinical reasons is appropriate.

(b) The physician conducting the review and making the adverse determination must:

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

(2) have the same or similar medical specialty as a provider that typically treats or manages the condition 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) Notwithstanding paragraph (a), a review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

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

(f) A utilization review organization is prohibited from using any form of automated processing alone without a clinician review by an appropriate health professional, as required under this section, when making an adverse determination.

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 an adverse determination for a mental health or substance abuse service for clinical reasons is appropriate, provided that any final adverse determination 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 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 adverse determination to 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.

Subd. 4. **Dentist plan reviews.** A dentist must review all cases in which the utilization review organization has concluded that an adverse determination for 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 an adverse determination for 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 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.

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 Osteopathic Association.

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. [Repealed, 2012 c 247 art 1 s 32]

**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; 2009 c 159 s 2; 2010 c 199 s 1; 2017 c 40 art 1 s 121; 2020 c 114 art 1 s 16; art 2 s 11-14; 2026 c 124 art 3 s 6*

**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 during reasonable and normal business 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.** (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 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 language that is easily understandable to providers. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(c) Effective January 1, 2026, the commissioner of human services must post on the department's public website the prior authorization requirements and restrictions, including written, evidence-based, clinical criteria used to make an authorization or adverse determination, that apply to prior authorization determinations for fee-for-service under chapters 256B and 256L. These prior authorization requirements and restrictions must be detailed and written in language that is easily understandable to providers.

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. A health plan company must post on its website the new or amended requirement or restriction. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(b) At least 45 days before a new prior authorization requirement or restriction or an amended existing prior authorization requirement or restriction is implemented, the utilization review organization, health plan company, or claims administrator must provide written or electronic notice of the new or amended requirement or restriction to all Minnesota-based, in-network attending health care professionals who are subject to the prior authorization requirements and restrictions. This paragraph does not apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L.

(c) Effective January 1, 2026, before the commissioner of human services may implement a new prior authorization requirement or restriction or amend an existing prior authorization requirement or restriction, the commissioner, at least 45 days before the new or amended requirement or restriction takes effect, must provide written or electronic notice of the new or amended requirement or restriction, to all health care professionals participating as fee-for-service providers under chapters 256B and 256L who are subject to the prior authorization requirements and restrictions.

**History:** *1992 c 574 s 10; 1995 c 234 art 8 s 14; 1999 c 239 s 27-29; 2001 c 137 s 6; 2020 c 114 art 1 s 17,18; 2024 c 127 art 57 s 28,29*

## 62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of this chapter, an enrollee may file a complaint regarding an adverse determination directly to the commissioner responsible for regulating the utilization review organization.

**History:** *1992 c 574 s 11; 2020 c 114 art 2 s 15*

## 62M.12 PROHIBITION OF INAPPROPRIATE INCENTIVES.

No individual who is performing utilization review may receive any financial incentive based on the number of 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.

**History:** *1992 c 574 s 12; 1999 c 239 s 30; 2020 c 114 art 2 s 16*

## 62M.13 SEVERABILITY.

If any provisions of this chapter are held invalid, illegal, or unenforceable for any reason and in any respect, the holding does not affect the validity of the remainder of this chapter.

**History:** *1992 c 574 s 13; 2020 c 114 art 2 s 20*

## 62M.14 EFFECT OF COMPLIANCE.

Evidence of a utilization review organization's compliance or noncompliance with the provisions of 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.

**History:** *1992 c 574 s 14; 2020 c 114 art 2 s 20*

## 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 this chapter, 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; 2020 c 114 art 2 s 20*

## 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. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, or a calendar year for fee-for-service providers under chapters 256B and 256L, 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, the change in coverage terms or change in clinical criteria shall not apply until the next plan year, or the next calendar year for fee-for-service providers under chapters 256B and 256L, 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.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm. This paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or renewed on or after that date.

(d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued, or renewed on or after that date, paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

(e) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

**History:** *2020 c 114 art 1 s 19; 2024 c 127 art 57 s 30; 1Sp2025 c 3 art 8 s 2*

**62M.18 ANNUAL POSTING ON WEBSITE; PRIOR AUTHORIZATIONS.**

(a) By April 1, 2022, and each April 1 thereafter, a health plan company must post on the health plan company's public website the following data for the immediately preceding calendar year for each commercial product:

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

(2) the number of prior authorization requests for which an adverse determination was issued and sorted by: (i) health care service; (ii) whether the adverse determination was appealed; and (iii) whether the adverse determination was upheld or reversed on appeal;

(3) the number of prior authorization requests that were submitted electronically and not by facsimile or email or other method pursuant to section 62J.497; and

(4) the reasons for prior authorization denial including but not limited to:

(i) patient did not meet prior authorization criteria;

(ii) incomplete information submitted by the provider to the utilization review organization;

(iii) change in treatment program; and

(iv) the patient is no longer covered by the plan.

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

**History:** *2020 c 114 art 1 s 20*

**62M.19 ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR AUTHORIZATIONS.**

On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data:

(1) the total number of prior authorization requests received;

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

(3) the number of prior authorization requests for which an adverse determination was issued;

(4) the number of adverse determinations reversed on appeal;

(5) the 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;

(6) the 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;

(7) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;

(8) the 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and

(9) the reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations. The reasons listed may include but are not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) incomplete information was submitted by the provider to the utilization review organization;

(iii) the treatment program changed; and

(iv) the patient is no longer covered by the health benefit plan.

**History:** *2024 c 127 art 57 s 31*