CHAPTER 62M

UTILIZATION REVIEW OF HEALTH CARE

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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 fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. **Scope.** Sections 62M.02, 62M.07, and 62M.09, subdivision 4, apply to prior authorization of services. 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.

History: *1992 c 574 s 1*

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 a patient.

Subd. 4. **Attending physician.** "Attending physician" means the physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

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 carrier 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, physicians, hospitals, or others 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 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 or covered person 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 a patient'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 a patient'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 who has elected to contract for, or participate in, a health benefit plan for enrollee coverage or for dependent coverage.

Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health carrier to an employer or individual 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. 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 or covered person.

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 physician, 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 the imposition of a requirement that services be received by or upon referral from a participating provider.

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 or an integrated service network licensed under chapter 62N; 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*

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, 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, 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 utiliza-

tion 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, 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*

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. In addition to the enrollee, the utilization review organization must allow any licensed hospital, physician or the physician'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, hospitals, physicians, or other 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, health care 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 carrier 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 physician or provider 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 health care 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 physician 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 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*

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 and section 72A.201, subdivision 4a.

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

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

(a) 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 hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.201, subdivision 4a, 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 or patient; 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."

(b) When a determination is made not to certify a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination, within one working day after making the decision the attending physician and hospital must be notified by telephone and a written notification must be sent to the hospital, attending physician, and enrollee or patient. 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 attending physician or provider 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 attending physician.

Subd. 4. **Failure to provide necessary information.** A utilization review organiza-

tion must have written procedures to address the failure of a health care provider, patient, or representative of either to provide the necessary information for review. If the patient 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.

History: *1992 c 574 s 5; 1994 c 485 s 65; 1994 c 625 art 2 s 12*

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 an admission, procedure, service, or extension of stay. The right to appeal must be available to the enrollee or designee and to the attending physician. The right of appeal must be communicated to the enrollee or designee or to the attending physician, whomever initiated the original certification request, at the time that the original determination is communicated.

Subd. 2. **Expedited appeal.** When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the utilization review organization must ensure that the attending physician, enrollee, or designee has 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. Expedited appeals that are not resolved may be resubmitted through the standard appeal process.

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

(a) Each utilization review organization shall notify in writing the enrollee or patient, attending physician, and claims administrator of its determination on the appeal as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the health care provider.

(c) Prior to upholding the original decision 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 original determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the patient, enrollee, or attending physician when the initial determination is made.

(e) An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending physician, 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.

Subd. 4. **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 6; 1994 c 625 art 2 s 13*

62M.07 PRIOR AUTHORIZATION OF SERVICES.

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 72A.201, subdivision 4a, 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 section 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

History: *1992 c 574 s 7; 1994 c 485 s 65*

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 physician.

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 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 the periodic evaluation and updating of the written criteria.

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*

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 hospitals' and physicians' 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 physician 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, hospitals, physicians, and other health care professionals 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.

History: *1992 c 574 s 10*

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 plans and their providers.

History: *1992 c 574 s 12*

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, or 72A.

History: *1992 c 574 s 15*

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*