CHAPTER 62M

UTILIZATION REVIEW OF HEALTH CARE

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 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.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

History: *1995 c 234 art 8 s 12*

62M.09 STAFF AND PROGRAM QUALIFICATIONS.

[For text of subds 1 to 4a, see M.S.1994]

Subd. 5. **Written clinical criteria.** A utilization review organization's decisions must be supported by written clinical criteria and review procedures in compliance with section 62M.07, paragraph (c). Clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the certification request. The utilization review organization must have a procedure for ensuring, at a minimum, the annual evaluation and updating of the written criteria based on sound clinical principles.

[For text of subds 6 to 8, see M.S.1994]

History: *1995 c 234 art 8 s 13*

62M.10 ACCESSIBILITY AND ON–SITE REVIEW PROCEDURES.

[For text of subds 1 to 6, see M.S.1994]

Subd. 7. **Availability of criteria.** Upon request, a utilization review organization shall provide to an enrollee or to an attending physician or provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

History: *1995 c 234 art 8 s 14*