CHAPTER 62M

UTILIZATION REVIEW OF HEALTH CARE

62M.02 DEFINITIONS.

[For text of subds 1 to 20, see M.S.2000]

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 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 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. 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: *1Sp2001 c 9 art 16 s 5*

62M.03 COMPLIANCE WITH STANDARDS.

[For text of subd 1, see M.S.2000]

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. 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.

[For text of subd 3, see M.S.2000]

History: *2001 c 215 s 24*

62M.05 PROCEDURES FOR REVIEW DETERMINATION.

[For text of subds 1 to 4, see M.S.2000]

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 certification or determination not to certify to the appropriate claims administrator for the health benefit plan. If it is determined by the claims administrator that the certified 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: *2001 c 215 s 25*

62M.06 APPEALS OF DETERMINATIONS NOT TO CERTIFY.

[For text of subds 1 and 2, see M.S.2000]

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

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 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 30-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.

(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 attending health care professional.

(c) Prior to upholding the initial determination 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 initial 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 enrollee and attending health care professional when the initial determination is made.

(e) An attending health care professional or enrollee 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 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.

(g) If the initial 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 the external process.

[For text of subd 4, see M.S.2000]

History: *2001 c 137 s 1*

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

[For text of subds 1 and 2, see M.S.2000]

Subd. 3. **Physician reviewer involvement.** (a) A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

(b) The physician conducting the review must be licensed in this state. This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota comprehensive health association.

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

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

Subd. 3a. **Mental health and substance abuse reviews.** A peer of the treating mental health or substance abuse provider or a physician must review requests for outpatient services in which the utilization review organization has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate, provided that any final determination not to certify treatment is made by a psychiatrist certified by the American Board of Psychiatry and Neurology and appropriately licensed in this state. Notwithstanding the notification requirements of section 62M.05, a utilization review organization that has made an initial decision to certify in accordance with the requirements of section 62M.05 may elect to provide notification of a determination to continue coverage through facsimile or mail. This subdivision does not apply to determinations made in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota comprehensive health association.

[For text of subds 4 to 5, see M.S.2000]

Subd. 6. **Physician consultants.** A utilization review organization must use physician consultants in the appeal process described in section 62M.06, subdivision 3. The physician consultants must be board certified by the American Board of Medical Specialists or the American Board of Osteopathy.

[For text of subds 7 and 8, see M.S.2000]

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

(1) per 1,000 claims, the number and rate of claims denied based on medical necessity for each procedure or service; and

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

History: *2001 c 137 s 2-5*

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

[For text of subds 1 to 6, see M.S.2000]

Subd. 7. **Availability of criteria.** Upon request, a utilization review organization shall 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.

History: *2001 c 137 s 6*