HOUSE BILL NO. 555

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A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATED TO UTILIZATION REVIEW; REDUCING TIME PERIODS FOR CERTAIN UTILIZATION REVIEW DETERMINATIONS; REQUIRING THE STATE MEDICAID PROGRAM TO COMPLY WITH THE UTILIZATION REVIEW REQUIREMENTS; PROVIDING DEFINITIONS; AMENDING SECTIONS 33-32-101, 33-32-102, 33-32-211, 33-32-212, 33-32-215, AND 53-6-113, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-32-101, MCA, is amended to read:

"33-32-101. Purpose. The legislature finds and declares that it is the purpose of this chapter to:

(1) promote the delivery of quality health care in a ~~cost-effective~~ COST-EFFECTIVE manner ~~that fairly balances cost-effective administration and timely, optimal patient care~~;

(2) foster greater coordination between health care providers, third-party payors, and others who conduct utilization review activities;

(3) ensure timely access to health care services;

~~(4) ensure the relationship between a health care provider and a patient is paramount and not subjected to unreasonable third-party intrusion, interference, or delay;~~

(4) PRESERVE THE INTEGRITY OF THE HEALTH CARE PROVIDER AND PATIENT RELATIONSHIP;

~~(4)~~(5) protect patients, employers, and health care providers by:

(a) ensuring that utilization review activities result in informed decisions on the appropriateness of medical care made by those best qualified to be involved in the utilization review process; and

(b) establishing the use of written clinical criteria for utilization review programs and reviews by appropriate health care providers to ensure a fair and transparent process for patients; ~~and~~ AND

~~(5)~~(6) establish written standards and clinical criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care

services~~; and~~

~~(7) clarify that utilization review programs may not hinder patient care or intrude upon the practice of medicine or services provided by other health care providers~~."

Section 2. Section 33-32-102, MCA, is amended to read:

"33-32-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Adverse determination", except as provided in 33-32-402, means:

(a) a determination by a health insurance issuer or its designated utilization review organization that, based on the provided information and after application of any utilization review technique, a requested benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not made in whole or in part for the requested benefit because the requested benefit does not meet the health insurance issuer's requirement for medical necessity~~, and~~, appropriateness~~, health care setting, level of care, or level of effectiveness~~, HEALTH CARE SETTING, LEVEL OF CARE, OR LEVEL OF EFFECTIVENESS or is determined to be experimental or investigational;

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a person's eligibility to participate in the health insurance issuer's health plan;

(c) any prospective review or retrospective review of a benefit determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit; or

(d) a rescission of coverage determination.

(2) "Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means:

(a) a person to whom a covered person has given express written consent to represent the covered person;

(b) a person authorized by law to provided substituted consent for a covered person; or

(c) a family member of the covered person or the covered person's treating health care provider only if the covered person is unable to provide consent.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or otherwise complex health conditions.

(5) "Certification" means a determination by a health insurance issuer or its designated utilization review organization that:

~~(a)~~ an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity~~,~~, and appropriateness~~, health care setting, level of care, and level of effectiveness~~, HEALTH CARE SETTING, LEVEL OF CARE, AND LEVEL OF EFFECTIVENESS~~; and~~

~~(b) payment will be made for the admission, availability of care, continued stay, or other heath care service~~.

(6) "Clinical peer" means a physician or other health care provider who:

(a) holds a nonrestricted license in a state of the United States; and

(b) is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written policies, written screening procedures, ~~drug formularies or lists of covered drugs,~~ decision abstracts, determination rules, clinical and medical protocols, ~~and~~ practice guidelines, or any other criteria or rationale used by a health insurance issuer or its designated utilization review organization to determine the MEDICAL necessity ~~and appropriateness~~ of health care services.

(8) "Concurrent review" means a utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or another inpatient or outpatient health care setting.

(9) "Cost sharing" means the share of costs that a covered member pays under the health insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

(10) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health plan.

(11) "Covered person" means a policyholder, a certificate holder, a member, a subscriber, an enrollee, or another individual participating in a health plan.

(12) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

(13) "Emergency medical condition" has the meaning provided in 33-36-103.

(14) "Emergency services" has the meaning provided in 33-36-103.

(15) "External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.

(16) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer or its designated utilization review organization at the completion of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.

(17) "Grievance" means a written complaint or an oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for health care services; or

(c) matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

(18) "Health care provider" or "provider" means a person, corporation, facility, or institution licensed by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:

(a) a physician, physician assistant, ADVANCED PRACTICE REGISTERED NURSE, health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed professional counselor; and

(b) an officer, employee, or agent of a person described in subsection (18)(a) acting in the course and scope of employment.

(19) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or durable medical equipment.

(20) "Health insurance issuer" has the meaning provided in 33-22-140.

(21) "Medical necessity" means health care services that a ~~prudent~~ health care provider EXERCISING PRUDENT CLINICAL JUDGMENT would provide to a patient for the purpose of preventing, EVALUATING, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms ~~in a manner~~ AND that ARE:

(a) ~~is~~ in accordance with generally accepted standards of practice;

(b) ~~is~~ clinically appropriate in terms of type, frequency, extent, site, and duration AND ARE CONSIDERED EFFECTIVE FOR THE PATIENT'S ILLNESS, INJURY, OR DISEASE; and

(c) ~~is~~ not primarily ~~for the economic benefit of the health insurance issuer and purchasers or~~ for the convenience of the patient or health care provider AND NOT MORE COSTLY THAN AN ALTERNATIVE SERVICE OR SEQUENCE OF SERVICES AT LEAST AS LIKELY TO PRODUCE EQUIVALENT THERAPEUTIC OR DIAGNOSTIC RESULTS AS TO THE DIAGNOSIS OR TREATMENT OF THE PATIENT'S ILLNESS, INJURY, OR DISEASE.

~~(21)~~(22) "Network" means the group of participating providers providing services to a managed care plan.

~~(22)~~(23) "Participating provider" means a health care provider who, under a contract with a health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

~~(23)~~(24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in this subsection.

(25) "PRESERVICE CLAIM" MEANS A REQUEST FOR BENEFITS OR PAYMENT FROM A HEALTH INSURANCE ISSUER FOR HEALTH CARE SERVICES THAT, UNDER THE TERMS OF THE HEALTH INSURANCE ISSUER'S CONTRACT OF COVERAGE, REQUIRES AUTHORIZATION FROM THE HEALTH INSURANCE ISSUER OR FROM THE HEALTH INSURANCE ISSUER'S DESIGNATED UTILIZATION REVIEW ORGANIZATION PRIOR TO RECEIVING THE SERVICES.

~~(24)~~~~(25)~~(26) "Prospective review" means a utilization review conducted OF A PRESERVICE CLAIM prior to an admission or a course of treatment.

~~(25)~~~~(26)~~(27) (a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance under a health plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

~~(26)~~~~(27)~~(28) (a) "Retrospective review" means a review of medical necessity conducted after services have been provided to a covered person.

(b) The term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

~~(27)~~~~(28)~~(29) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a

health care provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

~~(28)~~(29)(30) "Stabilize" means, with respect to an emergency condition, to ensure that no material deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the transfer of the individual from a facility.

~~(29)~~(30)(31) (a) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination could:

(i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) subject the covered person, in the opinion of a health care provider with knowledge of the covered person's medical condition, to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b) Except as provided in subsection ~~(29)(c)~~ ~~(30)(c)~~ (31)(C), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a health care provider with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subsection ~~(29)(a)~~ ~~(30)(a)~~ (31)(A) must be treated as an urgent care request.

~~(30)~~(31)(32) "Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

~~(31)~~(32)(33) "Utilization review organization" means an entity~~, including a health insurance issuer providing review for its own health plans,~~ that conducts utilization review~~, other than a health insurance issuer performing a review for its own health plans~~ for one or more of the following:

(a) an employer with employees who are covered under a health benefit plan or health insurance policy;

(b) a health insurance issuer PROVIDING REVIEW FOR ITS OWN HEALTH PLANS OR FOR THE HEALTH PLANS OF ANOTHER HEALTH INSURANCE ISSUER;

(c) a preferred provider organization or health maintenance organization;

(d) a state government agency that provides a health benefit plan, including the medical assistance

program provided for in Title 53, chapter 6; and

(e) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract."

Section 3. Section 33-32-211, MCA, is amended to read:

"33-32-211. Procedures for standard utilization review and benefit determinations -- notices. (1) A health insurance issuer shall establish ~~written procedures, as provided in this section,~~ WRITTEN PROCEDURES AND clinical review criteria for conducting standard utilization reviews and making benefit determinations on requests for benefits submitted to the health insurance issuer by covered persons or their authorized representatives. The written procedures must also include provisions for notifying covered persons or, if applicable, their authorized representatives of the health insurance issuer's determinations with respect to these requests within the timeframes specified in this section.

(2) (a) Subject to subsection (2)(c), for prospective review determinations, a health insurance issuer shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the health insurance issuer certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition. The notification must be made not later than ~~15~~ ~~3~~ 5 BUSINESS days after the date the health insurance issuer receives the request OR NOT LATER THAN 5 BUSINESS DAYS AFTER THE HEALTH INSURANCE ISSUER RECEIVES ALL INFORMATION UNDER SUBSECTION (2)(D) NECESSARY TO MAKE A DETERMINATION.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notification of the adverse determination in writing in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (2)(a) may be extended one time by the health insurance issuer for up to ~~15~~ ~~3~~ 5 BUSINESS days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial ~~15-day~~ ~~3-day~~ 5-BUSINESS-DAY period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (2)(c) is necessary because of the failure of the covered person

or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the required information necessary to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least ~~45~~ 5 BUSINESS days after the date of receipt of the notice to provide the specified information.

(3) (a) If the health insurance issuer receives from a covered person or, if applicable, the covered person's authorized representative a prospective review request that fails to meet the health insurance issuer's filing procedures, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice any information regarding the proper procedures to be followed for filing a request.

(b) The notice required under subsection (3)(a) must be provided ~~in writing~~ as soon as possible but not later than ~~5 days~~ ~~1 day~~ 3 DAYS after the date of the failure. ~~The health insurance issuer may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically.~~ THE HEALTH INSURANCE ISSUER MAY PROVIDE THE NOTICE ORALLY OR, IF REQUESTED BY THE COVERED PERSON OR THE COVERED PERSON'S AUTHORIZED REPRESENTATIVE, IN WRITING OR ELECTRONICALLY.

(c) To qualify for the provisions of this subsection (3) related to a failed filing procedure, the communication must:

(i) have been sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or an organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) refer to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which certification is being requested.

(4) For concurrent review determinations, if a health insurance issuer has certified an ongoing course of treatment to be provided over a period of time or a specified number of treatments:

(a) any reduction or termination by the health insurance issuer during the course of treatment before the end of the period or the specified number of treatments, other than by health plan amendment or termination of the health plan, constitutes an adverse determination; and

(b) the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of the adverse determination in accordance with subsection (8) at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's

authorized representative to:

(i) file a grievance requesting a review of the adverse determination pursuant to Title 33, chapter 32, parts 3 and 4; and

(ii) obtain a determination with respect to the review of the adverse determination before the benefit is reduced or terminated.

(5) The health care service or treatment that is the subject of the adverse determination must be continued without liability to the covered person pending a determination under the internal review request made pursuant to Title 33, chapter 32, part 3.

(6) (a) For retrospective review determinations, a health insurance issuer shall make the determination no later than 30 days after the date of receiving the benefit request.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (6)(a) may be extended one time by the health insurance issuer for up to 15 days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (6)(c) is necessary because of the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the information required to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least ~~45~~ 5 BUSINESS days after the date of receipt of the notice to provide the specified information.

(7) (a) For purposes of this section, the period within which a determination must be made begins on the date the request is received by the health insurance issuer in accordance with the health insurance issuer's procedures, established pursuant to 33-32-207, for filing a request. The date the request is received by the health

insurance issuer must be counted without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(b) If the period for making the determination under this section is extended due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit the information necessary to make the determination, the period for making the determination is counted from the date on which the health insurance issuer sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i) the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

(ii) the date on which the specified information was to have been submitted.

(c) If the covered person or, if applicable, the covered person's authorized representative fails to submit the information before the end of the extension period, as specified in this section, the health insurance issuer may deny the certification of the requested benefit.

(8) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, and the claim amount;

(b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information to the covered person or, if applicable, the covered person's authorized representative as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to Title 33, chapter 32, part 3, or a request for external review as outlined in Title 33, chapter 32, part 4.

(c) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(d) a reference to the specific plan provision on which the determination is based;

(e) a description of any additional material or information necessary for the covered person or, if applicable, the covered person's authorized representative to complete the benefit request, including an

explanation of why the material or information is necessary to complete the request;

(f) a description of the health insurance issuer's grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(g) a copy of any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(h) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request. The explanation under this subsection (8)(h) must apply the terms of the health plan to the covered person's medical circumstances.

(i) a statement explaining the availability of further assistance from the commissioner's office and the right of the covered person or, if applicable, the covered person's authorized representative to contact the commissioner's office at any time for assistance or, on completion of the health insurance issuer's grievance procedure and the external review process as provided under Title 33, chapter 32, parts 3 and 4, to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(9) (a) A health insurance issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner as required in accordance with federal regulations, including 45 CFR 147.136(e), and rules adopted pursuant to Title 33, chapter 32, part 3.

(b) To satisfy the provisions of subsection (9)(a), the health insurance issuer shall, at a minimum:

(i) provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests, claims, and appeals in any applicable non-English language;

(ii) provide, upon request, a notice in any applicable non-English language; and

(iii) include in the English version of the notice a prominently displayed statement in any applicable non-English language clearly indicating how to access the language services provided by the health insurance issuer.

(c) For purposes of this subsection (9), with respect to any United States county to which a notice is sent,

a non-English language is an applicable non-English language if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in federal guidance.

(10) ~~(a) Unless the covered person loses coverage under the applicable health plan or other health insurance coverage, the health insurance issuer may not revoke, limit, condition, or restrict a certification for a period of 45 working days from the date the health care provider received the certification. Any language attempting to disclaim payment for services that have received certification within the 45-day period is void.~~

~~(b) If the adverse determination is a rescission~~ a health insurance issuer rescinds a certification ~~IF THE~~ ADVERSE DETERMINATION IS A RECISSION, the health insurance issuer shall provide, in addition to any applicable disclosures required under this section, in a notice sent at least 30 days in advance of implementing the rescission decision:

(a) clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(b) an explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) the date when the advance notice period ends and the date to which the coverage is to be retroactively rescinded;

(d) notice that the covered person or, if applicable, the covered person's authorized representative may immediately file a grievance with the health insurance issuer requesting a review of the rescission; and

(e) a description of the health insurance issuer's grievance procedures, including any time limits applicable to these procedures.

(11) A health insurance issuer may provide the notices required under this section in writing or electronically."

Section 4. Section 33-32-212, MCA, is amended to read:

"33-32-212. Procedures for expedited utilization review and benefit determinations. (1) With respect to urgent care requests and concurrent review urgent care requests, a health insurance issuer shall establish ~~written procedures~~ WRITTEN PROCEDURES AND clinical review criteria for receiving benefit requests from covered persons or, if applicable, their authorized representatives, for conducting an expedited utilization review and making benefit determinations, and for notifying the covered persons or their authorized representatives of the expedited utilization review and benefit determinations.

(2) (a) The procedures established under subsection (1) must include a requirement for the health insurance issuer to provide that, in the case of a failure by a covered person or, if applicable, the covered person's authorized representative to follow the health insurance issuer's procedures for filing an urgent care request, the covered person or the covered person's authorized representative must be notified of the failure and the proper procedures to be followed for filing the request.

(b) The notice required under subsection (2)(a):

(i) must be provided to the covered person or, if applicable, the covered person's authorized representative not later than 24 hours after receipt of the request; and

(ii) may be made orally, unless the covered person or, if applicable, the covered person's authorized representative requests the notice in writing or electronically.

(c) To qualify for the provisions of this subsection (2) related to a failed filing procedure, the communication must:

(i) be sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) contain a reference to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which approval is being requested.

(3) (a) For an urgent care request, unless the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health insurance issuer to determine whether or to what extent the benefits requested are covered benefits or payable under the health insurance issuer's health plan, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative as soon as possible, taking into account the medical condition of the covered person, but no later than ~~72 hours~~ ~~1 business day~~ 48 HOURS after the receipt of the request by the health insurance issuer.

(b) With respect to the request, the health insurance issuer shall state in the notification whether or not the determination is an adverse determination. If the health insurance issuer's determination is an adverse determination, the notice must comply with the provisions of subsection (7).

(4) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health insurance issuer to make a determination, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative either orally

or, if requested by the covered person or the covered person's authorized representative, in writing or electronically of this failure and identify what specific information is needed. This notification must be made as soon as possible but not later than 24 hours after receipt of the request.

(b) The health insurance issuer shall, taking into account the circumstances, provide the covered person or, if applicable, the covered person's authorized representative with a reasonable period of time to submit the necessary information. The reasonable period may not end less than 48 hours after the health insurance issuer notifies the covered person or, if applicable, the covered person's authorized representative of the failure to submit sufficient information as provided in subsection (4)(a).

(c) A health insurance issuer shall, in cases in which more information is required as provided in subsection (4)(a), notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but not later than ~~48~~ 24 hours after the earlier of:

(i) the health insurance issuer's receipt of the requested information; or

(ii) the end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested information.

(d) If the covered person or, if applicable, the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection (4)(b), the health insurance issuer may deny the certification of the requested benefit.

(e) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination in accordance with subsection (7).

(5) (a) For concurrent review urgent care requests involving a request by the covered person or, if applicable, the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the health insurance issuer shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but not later than 24 hours after the health insurance issuer's receipt of the request.

(b) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination as provided in subsection (7).

(6) For the purposes of this section, the time period within which a determination must be made begins on the date and at the time the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to 33-32-207 for filing a request. The date and time the request is received by the health insurance issuer must be counted without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(7) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, and the claim amount;

(b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to Title 33, chapter 32, part 3, or a request for external review as outlined in Title 33, chapter 32, part 4.

(c) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(d) a reference to the specific plan provisions on which the determination is based;

(e) a description of any additional material or information necessary for the covered person or, if applicable, the covered person's authorized representative to complete the request, including an explanation of why the material or information is necessary to complete the request;

(f) a description of the health insurance issuer's internal grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(g) a description of the health insurance issuer's expedited grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(h) a copy of any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of

charge to the covered person on request.

(i) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request. The explanation under this subsection (7)(i) must apply the terms of the health plan to the covered person's medical circumstances.

(j) instructions for requesting any of the following that are applicable:

(i) a copy of the rule, guideline, protocol, or other similar criteria relied on in making the adverse determination in accordance with subsection (7)(h); or

(ii) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (7)(i); and

(k) a statement explaining the availability of further assistance from the commissioner's office and the right of the covered person or, if applicable, the covered person's authorized representative to contact the commissioner's office at any time for assistance or, on completion of the health insurance issuer's grievance procedure process as provided under Title 33, chapter 32, part 3, to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(8) A health insurance issuer shall provide the notice required under this section in the manner provided in 33-32-211(9).

(9) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within ~~3 days~~ ~~1 business day~~ 3 DAYS following the oral notification."

Section 5. Section 33-32-215, MCA, is amended to read:

"33-32-215. Emergency services. (1) When conducting a utilization review or making a benefit determination for emergency services, a health insurance issuer that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

(2) A health insurance issuer shall cover emergency services that screen and stabilize a covered person:

(a) without the need for prior authorization of the emergency services if a prudent lay person would have

reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

(b) without regard to whether the health care provider furnishing the services is a participating provider with respect to the emergency services;

(c) if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(d) if the emergency services are provided out-of-network, by complying with the cost-sharing requirements in subsection (4); and

(e) without regard to any other term or condition of coverage, other than:

(i) the exclusion of or coordination of benefits;

(ii) an affiliation or waiting period as permitted under 42 U.S.C. 300gg-19a; or

(iii) cost-sharing, as provided in subsection (4)(a) or (4)(b), as applicable.

(3) For in-network emergency services, coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

(4) (a) Except as provided in subsection (4)(b), for out-of-network emergency services, any cost-sharing requirement imposed with respect to a covered person may not exceed the cost-sharing requirement for a covered person if the services were provided in-network.

(b) A covered person may be required to pay, in addition to the in-network cost-sharing expenses, the excess amount the out-of-network provider charges that exceeds the amount the health insurance issuer is required to pay under this subsection (4).

(c) A health insurance issuer complies with the requirements of this section by paying for emergency services provided by an out-of-network provider in an amount not less than the greatest of the following and taking into account exceptions in subsections (4)(d) and (4)(e):

(i) the amount negotiated with in-network providers for emergency services, excluding any in-network cost-sharing imposed with respect to the covered person;

(ii) the amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(iii) the amount that would be paid under medicare for the emergency services, excluding any in-network

cost-sharing requirements.

(d) For capitated or other health plans that do not have a negotiated charge for each service for in-network providers, subsection (4)(c)(i) does not apply.

(e) If a health plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subsection (4)(c)(i) is the median of those negotiated amounts.

(5) Only in-network cost-sharing amounts may be imposed on out-of-network emergency services.

~~(6) If a health care provider certifies in writing to a health insurance issuer within 72 hours of a covered person's admission that the person's condition required prehospital transportation or emergency services, the certification creates a presumption for the medical necessity of the prehospital transportation and emergency services. The presumption of medical necessity may be rebutted only if the health insurance issuer provides clear and convincing evidence to the contrary.~~

~~(7)~~(6) A health insurance issuer shall allow a covered person, the person's authorized representative, and the person's health care provider at least 24 hours following an emergency admission or the provision of emergency services to notify the health insurance issuer of the admission or provision of emergency services. If the admission or the emergency services occur on a holiday or weekend, a health insurance issuer shall allow notification no later than by the next business day following the admission or provision of emergency services.

~~(6)~~~~(8)~~(7) If prior authorization is required for a postevaluation or poststabilization services review, a health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to facilitate the review."

NEW SECTION. **Section 6. Disclosure of utilization review requirements -- ~~statistics~~ DRUG BENEFIT INFORMATION.** (1) A utilization review organization shall make its current utilization review plan PREPARED PURSUANT TO 33-32-103, including clinical review criteria, standards, procedures, requirements, and restrictions, readily accessible on its website to covered persons, PROSPECTIVE COVERED PERSONS, and health care providers. The utilization review plan must be described in detail and in easily understandable language.

(2) If a utilization review organization intends to implement a new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, the entity may not implement the change until it has:

(a) notified health care providers in writing of the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, no less than 60 days

before the new or amended plan is to be implemented; and

(b) updated its website to reflect the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, to make the information accessible to covered persons, PROSPECTIVE COVERED PERSONS, AND health care providers~~, and the general public~~.

~~(3) A utilization review organization shall make available on its website statistics regarding utilization review approvals and denials. The information must be provided in a readily accessible format and include, at a minimum, categories for health care provider specialty, medication or diagnostic test or procedure, indication offered, and reason for denial.~~

(3) A HEALTH INSURANCE ISSUER OR UTILIZATION REVIEW ORGANIZATION, AS APPLICABLE, SHALL DISPLAY ON ITS PUBLIC WEBSITE CURRENT PRESCRIPTION DRUG BENEFIT INFORMATION, INCLUDING FORMULARY LISTS OF EACH PRESCRIPTION DRUG COVERED UNDER THE HEALTH INSURANCE ISSUER'S PLAN.

NEW SECTION. **Section 7. Length of prior authorization.** A certification by a utilization review organization approving health care services is valid for ~~1 year~~ AT LEAST 3 MONTHS from the date the health care provider receives the certification unless the covered person loses coverage under the applicable health plan or health insurance coverage.

NEW SECTION. **Section 8. Failure to comply.** (1) Any failure by a utilization review organization to comply with the deadlines and other requirements of this chapter results in certification ~~and approval for payment~~ for the health care services subject to review UNLESS THE FAILURE TO COMPLY IS DE MINIMUS.

(2) FOR THE PURPOSES OF SUBSECTION (1), A FAILURE TO COMPLY IS DE MINIMUS IF:

(A) IT DOES NOT CAUSE AND IS NOT LIKELY TO CAUSE PREJUDICE OR HARM TO THE COVERED PERSON;

(B) THE HEALTH INSURANCE ISSUER DEMONSTRATES THAT THE FAILURE WAS FOR GOOD CAUSE OR DUE TO MATTERS BEYOND THE CONTROL OF THE HEALTH INSURANCE ISSUER; AND

(C) IN THE CASE OF A FAILURE TO COMPLY WITH A UTILIZATION REVIEW DEADLINE, THE HEALTH CARE SERVICES SUBJECT TO REVIEW WERE NOT PROVIDED DURING THE TIME BETWEEN THE EXPIRATION OF THE DEADLINE AND THE NOTIFICATION OF THE INSURANCE ISSUER'S DETERMINATION OR LACK OF DETERMINATION.

Section 9. Section 53-6-113, MCA, is amended to read:

"53-6-113. Department to adopt rules. (1) The department shall adopt appropriate rules necessary for the administration of the Montana medicaid program as provided for in this part and that may be required by federal laws and regulations governing state participation in medicaid under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as amended.

(2) The department shall adopt rules that are necessary to further define for the purposes of this part the services provided under 53-6-101 and to provide that services being used are medically necessary and that the services are the most efficient and cost-effective available. The rules:

(a) may establish the amount, scope, and duration of services provided under the Montana medicaid program, including the items and components constituting the services; and

(b) must, if related to utilization review of services, comply with the utilization review timelines of Title 33, chapter 32.

(3) The department shall establish by rule the rates for reimbursement of services provided under this part. The department may in its discretion set rates of reimbursement that it determines necessary for the purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited to considering:

(a) the availability of appropriated funds;

(b) the actual cost of services;

(c) the quality of services;

(d) the professional knowledge and skills necessary for the delivery of services; and

(e) the availability of services.

(4) The department shall specify by rule those professionals who may deliver or direct the delivery of particular services.

(5) The department may provide by rule for payment by a recipient of a portion of the reimbursements established by the department for services provided under this part.

(6) (a) The department may adopt rules consistent with this part to govern eligibility for the Montana medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient information, and cooperation with the state agency administering the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq.

(b) The department may not apply financial criteria below $15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

(c) The department may not apply financial criteria below $15,000 for an individual and $30,000 for a couple for resources other than income in determining the eligibility of individuals for the medicaid program for workers with disabilities provided for in 53-6-195.

(7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or if funds appropriated are not sufficient to provide medical care for all eligible persons.

(8) The department may adopt rules necessary for the administration of medicaid managed care systems. Rules to be adopted may include but are not limited to rules concerning:

(a) participation in managed care;

(b) selection and qualifications for providers of managed care; and

(c) standards for the provision of managed care.

(9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended medical assistance will be provided. The department, in exercising its discretion to set income limits and duration of assistance, may consider the amount of funds appropriated by the legislature.

(10) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from medicaid services or require prior authorization for a child to access medicaid services if the child would be eligible for or able to access the services without prior authorization if the child was not in foster care."

NEW SECTION. **Section 10. Codification instruction.** [Sections 6 through 8] are intended to be codified as an integral part of Title 33, chapter 32, part 1, and the provisions of Title 33, chapter 32, part 1, apply to [sections 6 through 8].

NEW SECTION. **Section 11. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,

the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 12. Effective date -- APPLICABILITY.** [This act] is effective January 1, 2020, AND APPLIES TO PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 2020.

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