_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING UTILIZATION REVIEW LAWS; PROVIDING EXEMPTIONS FROM REVIEW UNDER CERTAIN CIRCUMSTANCES; ESTABLISHING REQUIREMENTS FOR INDIVIDUALS MAKING OR REVIEWING ADVERSE DETERMINATIONS; ESTABLISHING PROCEDURES FOR SUBMISSION OF PRESCRIPTION DRUG ORDERS REQUIRING REVIEW; ESTABLISHING REPORTING REQUIREMENTS; REVISING A DEFINITION; AND AMENDING SECTIONS 33-32-102, 33-32-106, 33-32-107, AND 33-32-208, MCA."

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

NEW SECTION. **Section 1. Exemption for continuity of care on change in health plans.** (1) When a covered person changes health plans, a utilization review organization shall honor a certification for health care services granted by a previous utilization review organization for at least the first 12 months of the person's coverage under a new health plan on receiving information documenting the certification from the covered person or the person's health care provider.

(2) During the time period specified in subsection (1), a utilization review organization may perform its own review to grant certification.

(3) If a change in coverage or approval criteria occurs for a previously certified health care service, the change in coverage or approval criteria does not affect a covered person who received certification for a health care service before the effective date of the change for the remainder of the covered person's plan year.

(4) A utilization review organization shall continue to honor a certification it has granted to a covered person when the person changes to a product offered by the same health insurance issuer.

(5) A utilization review organization may not discriminate against a covered person based on whether the person has a certification for services granted from a previous utilization review organization.

NEW SECTION. **Section 2. Exemption from utilization review for certain health care providers.**

(1) A utilization review organization may not require a health care provider to undergo utilization review for a health care service in order for the covered person to whom the service is being provided to receive coverage if, in the most recent 12-month period, the utilization review organization has certified or would have certified at least 80% of the utilization review requests submitted by the health care provider for the same health care service.

(2) A utilization review organization may not require a health care provider to complete a utilization review for any health care service if, in the most recent 12-month period, the utilization review organization has approved or would have approved at least 80% of the utilization review requests submitted by the health care provider for five separate health care services.

(3) A utilization review organization may not evaluate more frequently than every 12 months whether a health care provider continues to qualify for the exemptions allowed under this section.

(4) A health care provider is not required to request an exemption in order to qualify for an exemption.

(5) (a) A health care provider who does not receive an exemption may request evidence to support the utilization review organization's decision. The request may be made at any time but may not be made more than once a year for each service.

(b) A health care provider may appeal a utilization review organization's decision to deny an exemption.

(6) A utilization review organization shall provide a health care provider that receives an exemption a notice that includes:

(a) a statement that the health care provider qualifies for an exemption from utilization review requirements;

(b) a list of services to which the exemption applies; and

(c) a statement of the duration of the exemption.

(7) A utilization review organization may not deny or reduce payment for a health care service exempted from a utilization review requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered the service received an exemption, unless the rendering health care provider:

(a) knowingly and materially misrepresented the health care service in a request for payment submitted to the utilization review organization with the specific intent to deceive and obtain an unlawful payment from the utilization review organization; or

(b) failed to substantially perform the health care service.

(8) A utilization review organization may only revoke an exemption at the end of the 12-month period if the utilization review organization:

(a) makes a determination that the health care provider would not have met the 80% approval criteria based on a retrospective review of the claims for the specific service for which the exemption applies for the previous 3 months or a longer period if needed to reach a minimum of 10 claims for review;

(b) provides the health care provider with the information it relied on in making its determination to revoke the exemption; and

(c) provides the health care provider a plain language explanation of how to appeal the decision.

(9) An exemption remains in effect until the 30th day after the date the utilization review organization notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the 5th day after the revocation is upheld on appeal.

(10) A determination to revoke or deny an exemption must be made by a licensed health care provider. The provider must be of the same or similar specialty as the health care provider being considered for an exemption and have experience in providing the service for which the potential exemption applies.

(11) Nothing in this section requires a utilization review organization to evaluate an existing exemption or prevents a utilization review organization from establishing a longer exemption period.

NEW SECTION. **Section 3. Qualifications of individuals making or reviewing adverse determinations.** (1) A utilization review organization shall ensure that only a physician makes an adverse determination pursuant to 33-32-211 or 33-32-212 or reviews a grievance as provided under 33-32-308 or 33-32-309.

(2) A physician making an adverse determination or reviewing a grievance must:

(a) possess a current and valid nonrestricted license to practice medicine;

(b) be of the same specialty as the health care provider who typically manages the medical

condition or disease or provides the health care service involved in the request;

(c) have experience treating patients with the medical condition or disease for which the health care service is being requested; and

(d) make the adverse determination under the clinical direction of one of the utilization review organization's medical directors who is responsible for the provision of health care services provided to covered persons in the state. Any medical director used for this purpose must be a physician licensed in the state.

NEW SECTION. **Section 4. When certification is deemed.** The failure of a utilization review organization to comply with the deadlines and other requirements of this chapter results in the automatic deeming of certification for any health care service under review.

Section 5. 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, appropriateness, 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 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, appropriateness, health care setting, level of care, and level of effectiveness.

(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, decision abstracts, determination rules, clinical and medical protocols, 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 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 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 and that are:

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

(b) 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) not primarily 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.

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

(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.

(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.

(26) "Prospective review" means a utilization review, medical necessity review, or prior authorization, whether or not required by the utilization review organization, conducted of a preservice claim prior to an admission or a course of treatment. The term includes a requirement by a health insurance issuer or utilization review organization that a covered person or a health care provider notify the issuer or organization

prior to receiving or providing a health care service.

(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.

(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.

(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.

(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.

(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 (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 (31)(a) must be treated as an urgent care request.

(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.

(33) "Utilization review organization" means an entity that conducts utilization review 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; and

(d) 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 6. Section 33-32-106, MCA, is amended to read:

"**33-32-106. Disclosure of utilization review requirements -- 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.

(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.

(4) A utilization review organization shall make statistics regarding certifications and denials available in a readily accessible format on the organization's website, including:

(a) the specialty and licensure type of the health care providers who reviewed requests;

(b) the medications, diagnostic tests, and procedures reviewed;

(c) the determinations made;

(d) the reasons for adverse determinations;

(e) the number of grievances filed and the outcome of the appeals; and

(f) the time between the submission of a request and the response to the request."

Section 7. Section 33-32-107, MCA, is amended to read:

"**33-32-107. Length of prior authorization.** (1) A certification by a utilization review organization approving health care services is valid for at least ~~3~~ 12 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.

(2) A certification by a utilization review organization approving a health care service for treatment of a chronic or long-term care condition is valid for the length of the treatment. The utilization review organization may not require the covered person to obtain certification again for the same health care service."

Section 8. Section 33-32-208, MCA, is amended to read:

"**33-32-208. Operational requirements.** (1) A utilization review program must use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to ensure

ongoing efficacy. A health insurance issuer may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

(2) A health insurance issuer shall, on request, make available its clinical review criteria to authorized government agencies, including the commissioner.

(3) Qualified health care professionals shall administer and oversee the utilization review program.

(4) A health insurance issuer shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of 33-32-211 and 33-32-212.

(5) (a) Whenever a health insurance issuer fails to adhere to the requirements of 33-32-211 or 33-32-212, as applicable, with respect to conducting a utilization review and making benefit determinations of a benefit request or claim, the covered person is considered to have exhausted the provisions of this part and may take action under subsection (5)(b).

(b) A covered person may file a request for external review in accordance with the procedures outlined in Title 33, chapter 32, part 4. In addition to filing a request, a covered person is entitled to pursue any available remedies under state or federal law if the health insurance issuer failed to provide a reasonable internal claims and appeals process designed to yield a decision on the merits of the claim.

(6) (a) Section 33-32-211 or 33-32-212 may not be considered exhausted based on a de minimis violation that does not cause and is not likely to cause prejudice or harm to the covered person, as long as the health insurance issuer demonstrates that the violation was for good cause or was due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative.

(b) The exception provided in subsection (6)(a) does not apply if the violation is part of a pattern or practice of violations by the health insurance issuer.

(7) A health insurance issuer shall maintain a process to ensure that utilization reviewers apply clinical review criteria consistently in conducting utilization review.

(8) A health insurance issuer shall routinely assess the effectiveness and efficiency of its utilization review program.

(9) A health insurance issuer's data systems must be sufficient to support utilization review

program activities and to generate management reports to enable the health insurance issuer to monitor and manage health care services effectively.

(10) No later than January 1, 2025, the health insurance issuer may accept and respond to certification requests under the pharmacy benefit only through secure electronic transmissions made using the electronic prescribing standard approved by the centers for medicare and medicaid services. Facsimile, propriety payer portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record or electronic prescribing system may not be considered a secure electronic transmission.

~~(10)~~(11) If a health insurance issuer delegates any utilization review activities to a utilization review organization, the health insurance issuer shall maintain adequate oversight, which includes:

(a) a written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(b) evidence of formal approval of the utilization review organization's program by the health insurance issuer; and

(c) a process by which the health insurance issuer evaluates the performance of the utilization review organization.

~~(11)~~(12) A health insurance issuer shall coordinate its utilization review program with other medical management activity conducted by the health insurance issuer, such as quality assurance, credentialing, health care provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

~~(12)~~(13) A health insurance issuer shall provide covered persons and participating providers with access to the health insurance issuer's review staff through a toll-free number or collect-call telephone line.

~~(13)~~(14) When conducting a utilization review, a health insurance issuer shall collect only the information necessary, including pertinent clinical information, to conduct the utilization review or make the benefit determination.

~~(14)~~(15) (a) When conducting a utilization review, a health insurance issuer shall ensure that the review is conducted in a manner that ensures the independence and impartiality of the individuals involved in conducting the utilization review or making the benefit determination.

(b) In ensuring the independence and impartiality of individuals involved in the utilization review or benefit determination, a health insurance issuer may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based on the likelihood that the individual involved in the utilization review or benefit determination will support the denial of benefits."

NEW SECTION. **Section 9. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 32, part 2, and the provisions of Title 33, chapter 32, part 2, apply to [sections 1 and 2].

(2) [Sections 3 and 4] are intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [sections 3 and 4].

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