MN HOUSE RESEARCH

Chapter 114

2020 Regular Session

Subject Utilization review and prior authorization

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Article 1: Utilization review and prior authorization of health care services

This article makes changes to chapter 62M, which governs utilization review and prior authorization of health care services. Changes include:

- exempting from chapter 62M, managed care plans and county-based purchasing plans providing coverage to state public health care program enrollees;
- changing terms used for decisions adverse to the enrollee, and decisions in favor of the enrollee;
- defining additional terms;
- modifying timelines within which utilization review organizations must make standard determinations, expedited review determinations, and decisions under the standard appeal process;
- prohibiting retrospective revocation or limitation of a prior authorization;
- requiring prior authorization requirements and restrictions and data on prior authorizations to be posted on public websites; and
- providing for continuity of care regarding prior authorizations.

Section	Description
1	**Jurisdiction.** Amends § 62M.01, subd. 2. Amends a subdivision specifying the jurisdiction of chapter 62M, to specify that the chapter also applies to any entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits under a policy, plan, or contract.
2	**Scope.** Amends § 62M.01, subd. 3. Provides that chapter 62M does not apply to managed care plans or county-based purchasing plans providing coverage to medical assistance or MinnesotaCare enrollees.
3	**Adverse determination.** Adds subd. 1a to § 62M.02. Defines adverse determination as a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including a decision to

Section	Description

deny an admission, extension of stay, or health care service on the basis that the service is not medically necessary. ("Adverse determination" replaces the term "determination not to certify" currently used in chapter 62M).

4 **Authorization.**

Amends § 62M.02, subd. 5. Changes a term used in chapter 62M, from certification to authorization, and defines authorization as a determination by a utilization review organization that an admission, extension of stay, or other health care service satisfies the utilization review requirements of the applicable health plan and the health plan company will pay for the covered benefit.

5 **Clinical criteria.**

Amends § 62M.02, subd. 8. Modifies the definition of clinical criteria to specify it includes clinical protocols or any other criteria or rationale used by the utilization review organization to determine whether a health care service is authorized. Also changes another term used in the definition.

6 **Emergency services.**

Adds subd. 10a to § 62M.02. Defines emergency services for this chapter by reference to a definition in section 62Q.55, subdivision 3.

7 **Medically necessary care.**

Adds subd. 13a to § 62M.02. Defines medically necessary care for this chapter by reference to the definition in section 62Q.53.

8 **Utilization review.**

Amends § 62M.02, subd. 20. Amends the definition of utilization review to clarify that utilization review includes prior authorization.

9 **Utilization review organization.**

Amends § 62M.02, subd. 21. Amends the definition of utilization review organization to specify it includes any other entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits under a policy, plan, or contract. Also updates terms used.

10 **Standard review determination.**

Amends § 62M.05, subd. 3a. Current law requires a standard review determination to be communicated within ten business days. For 2021, a standard review determination must be communicated within five business days if received electronically or within six business days if received nonelectronically. For 2022 and future years, a standard review determination must be communicated within five business days regardless of how the request was received by the utilization review

Section	Description

organization. Also requires the written notification sent to the enrollee of the utilization review organization's determination to include all reasons relied on for the determination, rather than the principal reason relied on as in current law. Modifies terms used.

11 **Expedited review determination.**

Amends § 62M.05, subd. 3b. Requires a utilization review organization to provide to the hospital, attending health care professional, and enrollee, a determination on a request for expedited review within 48 hours after the initial request, rather than 72 hours as in current law. Requires this 48-hour period to include at least one business day. Modifies terms used.

12 **Failure to provide necessary information.**

Amends § 62M.05, subd. 4. Clarifies that a utilization review organization must have written procedures to address the failure of a provider or enrollee to provide information necessary to make a determination on the request. Also modifies a term used.

13 **Procedures for appeal.**

Amends § 62M.06, subd. 1. Strikes language exempting managed care plans and county-based purchasing plans serving state public health care program enrollees from a requirement related to appeals (these managed care plans and county-based purchasing plans are now exempt from the entire chapter).

14 **Standard appeal.**

Amends § 62M.06, subd. 3. For a standard appeal, requires a utilization review organization to notify the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 15 days after receipt of the notice of appeal, rather than 30 days as in current law. If a utilization review organization cannot make a determination with 15 days, allows it to take up to four additional days, rather than 14 additional days as in current law. Modifies terms used.

15 **Prior authorization of services.**

Amends § 62M.07. A new subdivision 3 prohibits a utilization review organization, health plan company, or claims administrator from revoking, limiting, conditioning, or restricting a prior authorization that has been authorized unless the prior authorization was authorized based on fraud or misinformation, or a previously approved prior authorization conflicts with state or federal law. Specifies that application of cost-sharing does not constitute a limit, condition, or restriction. In subdivisions 1, 2, and 4, clarifies language and modifies terms used.

Section	Description

16 **Physician reviewer; adverse determinations.**

Amends § 62M.09, subd. 3. Specifies that a physician must make the adverse determination in all cases where the utilization review organization has concluded an adverse determination for clinical reasons is appropriate. Requires this physician to hold a current, unrestricted Minnesota license to practice medicine and to have the same or similar medical specialty as the provider that typically manages the condition. Provides that a review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

17 **Availability of criteria.**

Amends § 62M.10, subd. 7. For prior authorizations, requires a utilization review organization to submit its prior authorization requirements and restrictions to all health plan companies for which it performs utilization review, and requires health plan companies to post these requirements and restrictions on its public website. Requires these requirements and restrictions to be detailed and written in language that is easily understandable to providers. (For utilization review determinations other than prior authorization, a utilization review organization must provide its criteria used to determine medical necessity, appropriateness, and efficacy to an enrollee, provider, and the commissioner of commerce upon request.)

18 **Notice; new prior authorization requirements or restrictions; changes to existing requirement or restriction.**

Adds subd. 8 to § 62M.10. Before a utilization review organization may implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, requires the organization to submit it to all health plan companies for which the organization performs utilization review, and requires the health plan company to post the new or amended requirement or restriction on its website. At least 45 days before a utilization review organization implements a new requirement or restriction or amends an existing requirement or restriction, requires the organization, health plan company, or claims administrator to provide written or electronic notice to all Minnesota-based, in-network attending health care professionals who are subject to the organization's prior authorization requirements and restrictions.

19 **Continuity of care; prior authorizations.**

Adds § 62M.17.

Subd. 1. Compliance with prior authorization approved by previous utilization review organization; change in health plan company. If an enrollee obtains health coverage from a new health plan company that uses an different utilization review organization from the enrollee's previous health benefit plan,

Section	Description

requires the enrollee's new health plan company to comply with prior authorizations issued for the enrollee's previous health benefit plan for at least the first 60 days the enrollee is covered under the new health benefit plan. To obtain this coverage, requires the enrollee or enrollee's attending health care professional to submit documentation to the enrollee's new health plan company.

Subd. 2. Effect of change in prior authorization clinical criteria. Paragraph (a) provides if a utilization review organization changes coverage terms for a health care service or clinical criteria used to conduct prior authorizations, prohibits the change in coverage terms or change in clinical criteria from applying until the next plan year, for any enrollee who received prior authorization for a service using the coverage terms or clinical criteria in effect before the effective date of the change.

Paragraphs (b), (c), and (d) establish exceptions to paragraph (a), and allow a change in coverage terms to apply during the plan year if: (1) coverage terms for a drug or device were changed because the drug or device was deemed unsafe, was withdrawn from the market, or was the subject of warning or recommended changes in use; (2) a utilization review organization changes coverage terms for a service or clinical criteria when an independent source of research, guidelines, or standards has recommended changes for reasons related to patient harm; or (3) a utilization review organization removes a brand name drug from its formulary or changes coverage of a drug so that an enrollee's costs are increased, as long as the organization meets the other conditions in that paragraph.

20 **Annual posting on website; prior authorizations.**

Adds § 62M.18. By April 1 of each year beginning in 2022, requires a health plan company to post on its public website the following information for the immediately preceding calendar year, for each commercial product:

- the number of prior authorization requests for which an authorization was issued;
- the number of prior authorization requests for which an adverse determination was issued, sorted by health care service, by whether the determination was appealed, and by whether the determination was upheld or reversed on appeal;
- the number of prior authorization requests that were submitted electronically; and
- the reasons for prior authorization denial.

Section	Description
	Requires information posted under this section to be written in easily understandable language.
21	**Compliance report on drug prior authorizations.** By April 1, 2021, requires the commissioner of health to submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, a report on provider compliance with requirements that drug prior authorization requests be submitted electronically through secure electronic transmissions. Lists information that must be included in the report.
22	**Repealer.** Repeals Minnesota Statutes, § 62M.02, subd. 19 (definition of reconsideration request for chapter 62M; this term is not used in that chapter). Also repeals Minnesota Rules, part 4685.0100, subpart 9b (definition of medically necessary care for a chapter regulating health maintenance organizations).

Article 2: Conforming changes

This article modifies terms used, changes references from a range of statutes to a reference to chapter 62M, removes references to chapter 62M in a section governing county-based purchasing plans, directs the revisor of statutes to modify a headnote and to change references, and makes other technical changes to conform with the changes made in article 1.