HOUSE RESEARCH

Bill Summary

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Subject: Utilization Review

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Overview

This bill modifies provisions governing utilization review, the process health plan companies use to determine whether health care treatments or procedures are medically necessary or appropriate. It requires physicians reviewing utilization review determinations to be licensed in Minnesota, requires physician consultants to be board-certified, requires certain annual reports by utilization review organizations, and requires the disclosure of criteria used to perform utilization reviews.

Section

1 **Standard appeal.** Amends § 62M.06, subd. 3. In subdivision governing appeals of utilization review determinations not to certify, requires a physician with the same or a similar specialty as typically manages the medical condition to be reasonably available to review the appeal. (Current law requires such a physician to review the appeal only at the request of the attending health care professional who ordered the health care treatment.)

2 **Physician reviewer involvement.** Amends § 62M.09, subd. 3. Requires physicians who review utilization review cases in which a determination has been made not to certify, to be licensed in Minnesota. Exempts health plan companies with less than 3 percent of the market from this requirement.

3 **Mental health and substance abuse reviews.** Amends § 62M.09, subd. 3a. Requires a psychiatrist who makes a final determination not to certify treatment to be currently practicing in the field of mental health or substance abuse treatment and to be licensed in Minnesota. Exempts health plan companies with less than 3 percent of the market from the licensing requirement.

4 **Physician consultants.** Amends § 62M.09, subd. 6. Requires physician consultants who participate in the utilization review appeals process to be board-certified by the American Board of Medical Specialists or the American Board of Osteopathy. (Current law requires such physicians to include physicians who are board-certified, as needed and available, or board

eligible and working toward certification.)

5 **Annual report.** Adds subd. 9 to § 62M.09. Requires utilization review organizations to annually report to the commissioner of commerce on the number and rate of claims denied per 1,000 claims based on medical necessity for each procedure, or service and the number and rate of denials overturned on appeal.

6 **Availability of criteria.** Amends § 62M.10, subd. 7. Requires a utilization review organization to provide, upon request, the commissioner of commerce with the criteria used to determine medical necessity, appropriateness, and efficacy of a procedure or service. (Current law requires this information to be provided to enrollees and providers.)