MN HOUSE RESEARCH

Utilization Review of Health Care Services

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Overview

Utilization review is the evaluation of the necessity, appropriateness, and efficacy of a health care service to determine whether the health care service is medically necessary for a patient. A health insurer may conduct utilization review of a health care service that a health care provider recommends for a patient, or may contract with a utilization review organization to perform utilization review.

Utilization review is governed by Minnesota Statutes, chapter 62M. This chapter of statutes was enacted in 1992, and significant amendments were enacted in 2020 and 2024. This publication summarizes state laws governing utilization review and the regulation of utilization review organizations.

Scope of Chapter 62M

Minnesota Statutes, chapter 62M, regulates utilization review organizations and establishes requirements for utilization review of health care services, admissions, and extensions of stays. This chapter applies to health insurers and entities listed in Minnesota Statutes, section 62M.01, subdivision 2. These include insurance companies selling accident and sickness insurance, health service plans, and health maintenance organizations; third-party administrators that provide utilization review services; any entity that provides, offers, or administers health benefits to individuals under a policy, plan, or contract; or any entity performing utilization review pursuant to a health benefit plan covering a Minnesota resident. In addition to these entities, effective January 1, 2026, chapter 62M applies to managed care plans and county-based purchasing plans providing coverage under Medical Assistance or MinnesotaCare, and certain sections in chapter 62M apply to services delivered to Medical Assistance and MinnesotaCare enrollees through fee-for-service. The appeals procedures in this chapter apply to any complaint that requires a medical determination in its resolution.

Chapter 62M does not apply to reviews of claims after submission to determine eligibility for benefits under a health benefit plan. (Minn. Stat. § 62M.01, subd. 3)

Utilization Review Defined

Utilization review is defined in statute as an evaluation, by a person or entity other than the patient's health care provider, of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities to determine the medical necessity of the service, procedure, or facility admission. (Minn. Stat. § 62M.02, subd. 20) Utilization review includes prior authorization, which is conducted before a service is delivered, and review

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conducted after a patient is admitted to a facility. When conducting utilization review, a utilization review organization may issue an authorization or an adverse determination.

- An ***authorization*** means the utilization review organization determines that the admission, extension of stay, or health care service satisfies the health benefit plan's utilization review requirements and the health plan company will pay for the covered benefit, provided other policy requirements are met. (Minn. Stat. § 62M.02, subd. 5)
- An ***adverse determination*** means the utilization review organization makes a decision relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee. An adverse determination includes a decision to deny an admission, extension of stay, or health care service because it is not medically necessary, or an authorization for a health care service that is less intensive than the service specified in the original request. (Minn. Stat. § 62M.02, subd. 1a)

Regulation of Utilization Review Organizations

A utilization review organization is defined as: an entity that conducts utilization review and makes authorizations or adverse determinations regarding an admission, extension of stay, or other health care service for a Minnesota resident; any entity that administers health benefits to individuals under a policy, plan, or contract; or any entity performing utilization review that conducts utilization review on behalf of a business entity in the state. (Minn. Stat. § 62M.02, subd. 21) In order to perform utilization review in this state, an organization must either:

- be licensed by the commissioner of health or commissioner of commerce, as applicable, as an insurance company licensed to sell accident and sickness insurance policies, a health service plan corporation, a health maintenance organization, a community integrated service network, an accountable provider network, or a fraternal benefit society; or
- register with the commissioner of commerce as a utilization review organization. A registration is valid for two years. (Minn. Stat. § 62M.03)

The commissioner of human services is not subject to section 62M.03 and is not required to be licensed or registered as provided in that section.

A utilization review organization must comply with chapter 62M and with section 72A.201, subdivisions 8 and 8a, which list grounds for denials of claims that constitute unfair settlement practices and establish qualifications for reviewers of chemical dependency claims. A utilization review organization that fails to comply with chapter 62M is prohibited from conducting utilization review for any Minnesota resident. The commissioner of commerce may issue a cease and desist order to enforce this provision. Additionally, the commissioner of commerce may use administrative remedies established in section 72A.201 against a nonlicensed utilization review organization that fails to comply with chapter 62M.

Prior Authorization

Prior authorization is utilization review that is conducted before delivery of a health care service. (Minn. Stat. § 62M.02, subd. 15) In order to allow providers to submit requests for prior authorization in a timely way, utilization review organizations must allow providers to submit most types of these requests by telephone, facsimile, voice mail, or through an electronic mechanism 24 hours a day, seven days a week. A utilization review organization that conducts prior authorization must have written standards governing prior authorization, including procedures to determine whether care is medically necessary and a system to promptly notify enrollees and providers of determinations and of the availability of appeals, appeal procedures, and procedures to ensure confidentiality of patient-specific information. Effective January 1, 2027, utilization review organizations must maintain an application programming interface that automates the prior authorization process for health care services, other than prescription drugs and medications. (Minn. Stat. § 62M.07, subds. 1, 4)

Limits on Use of Prior Authorization

Prior authorization is prohibited for an emergency service[1] or emergency confinement. Effective January 1, 2026, prior authorization is also prohibited for:

- outpatient mental health treatment or outpatient substance use disorder treatment, not including medications;
- antineoplastic cancer treatment consistent with National Comprehensive Cancer Network guidelines, not including medications;
- certain preventive services and immunizations;
- pediatric hospice services; and
- treatment delivered through a neonatal abstinence program. (Minn. Stat. § 62M.07, subd. 2)

Utilization review organizations, health plan companies, and claims administrators are prohibited from revoking, limiting, or conditioning prior authorization for an admission, extension of stay, or health care service once the prior authorization has been issued, unless the original authorization was issued based on fraud or misinformation or the authorization conflicts with law. (Minn. Stat. § 62M.07, subd. 3)

[1] Minnesota Statutes, section 62Q.55, subdivision 3, provides that emergency services means, with respect to an emergency medical condition: (1) as required under the federal Emergency Medical Treatment and Labor Act (EMTALA), a medical screening examination in a hospital emergency department to evaluate the emergency medical condition; (2) any further medical examination and treatment within the capabilities of the hospital, as required under EMTALA; and (3) immediate response services for a person experiencing a psychiatric crisis, mental health crisis, or emergency.

Effective January 1, 2026, an authorization for treatment of a chronic health condition[2] does not expire unless the standard of treatment for that health condition changes. This means a patient cannot be required to periodically obtain a new authorization for a health treatment the patient is receiving to treat a chronic condition, unless the standard of treatment for that condition changes. (Minn. Stat. § 62M.07, subd. 5)

Continuity of Care

Specific requirements exist to provide continuity of care for enrollees receiving health services that are subject to prior authorization, if changes in circumstances affect the ability of enrollees to continue to have those services authorized. If an enrollee obtains coverage from a new health plan company that uses a different utilization review organization from the enrollee's previous health plan company, the new health plan company must comply with a prior authorization granted by the previous health plan company for at least the first 60 days of coverage. During this period, the new health plan company may conduct its own utilization review of the service, with the determination from this utilization review taking effect after the 60-day period ends. Additionally, if a utilization review organization changes coverage terms for a health care service or changes the clinical criteria used to conduct prior authorization, that change does not apply to enrollees for whom prior authorization was granted using the previous terms or criteria until the next plan year. Certain exceptions apply to this provision. (Minn. Stat. § 62M.17)

Notice of New or Modified Requirement

Utilization review organizations must provide notice before implementing a new prior authorization requirement or modifying an existing requirement. The new or modified prior authorization requirement must be submitted to all health plan companies for which the organization performs utilization review, and these health plan companies must post the change on their websites. In addition, at least 45 days before a new or modified prior authorization requirement is implemented, notice must be provided to all Minnesota-based, in-network health care providers subject to the new or modified requirement. (Minn. Stat. § 62M.10, subd. 8)

Annual Postings and Reports

Health plan companies are required to annually post on their public websites, certain data regarding prior authorizations. This data includes the number of prior authorization requests that were authorized, the number for which an adverse determination was issued, the number that were submitted electronically, and the reasons for adverse determinations. (Minn. Stat. § 62M.18)

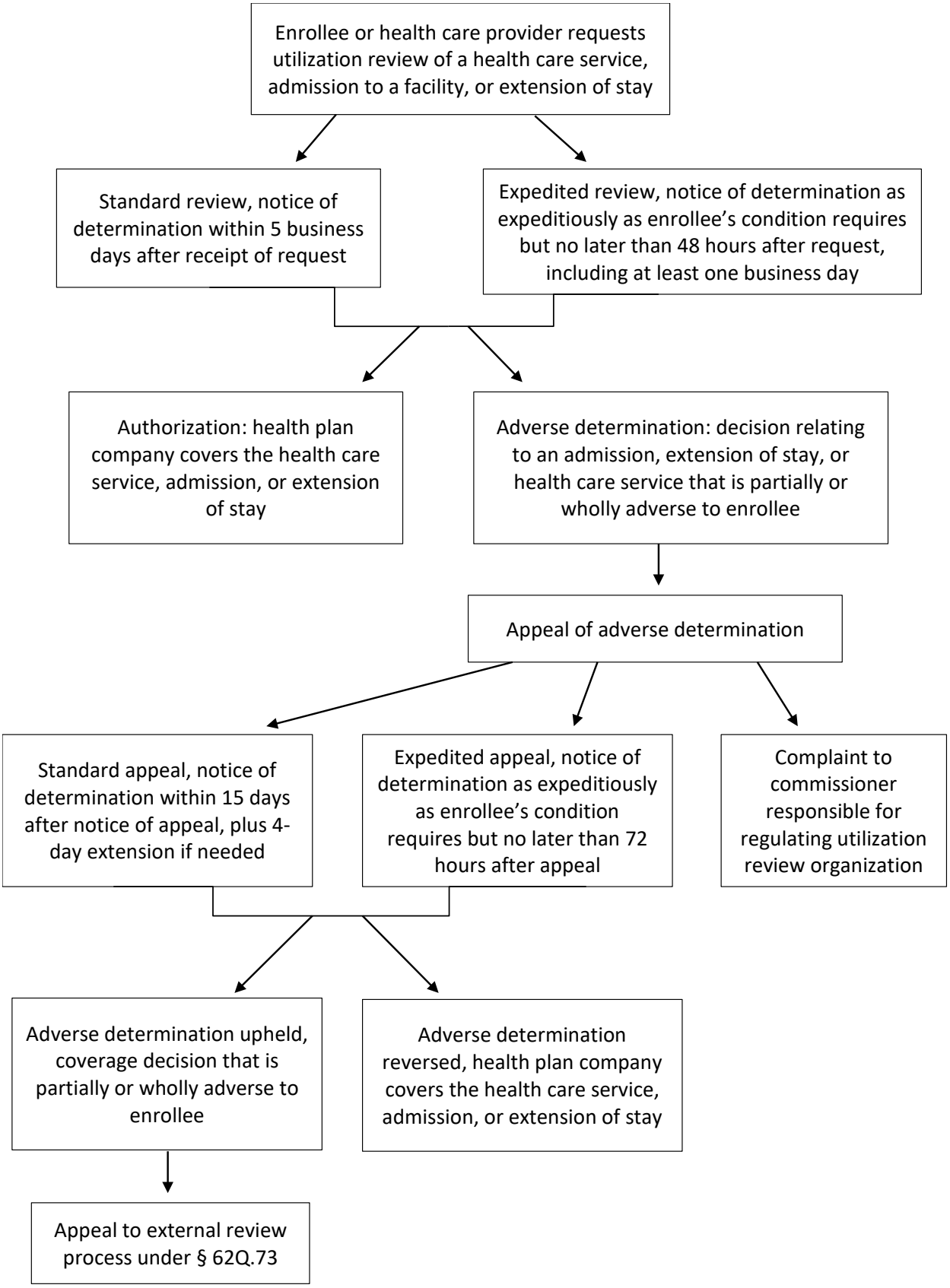
[2] A chronic health condition is defined as a condition that is expected to last one year or more and that either (1) requires ongoing medical attention to effectively manage it or prevent an adverse health event or (2) limits one or more activities of daily living.

Utilization review organizations are required to annually report to the commissioner of health, information on prior authorization requests for the previous calendar year. Reports must include the following data for the previous calendar year: the number of prior authorization requests received; the number of authorizations issued and the number of adverse determinations issued; the number of adverse determinations reversed on appeal; the 25 codes with the highest percentage of prior authorization requests; the 25 codes with the highest percentage of authorizations or adverse determinations; the 25 codes with the highest percentage of adverse determinations reversed on appeal; and the reasons adverse determinations were issued. (Minn. Stat. § 62M.19)

Utilization Review Process

Utilization review must be conducted according to the process in chapter 62M, including using written utilization review procedures and clinical criteria and complying with limits on the information used to conduct utilization review, the processes for standard review and expedited review, and the processes for appeals. The following chart illustrates the utilization review process.

Utilization Review Process



Notice of Process, Requirements, and Criteria

Enrollees must be provided with notice of the process for obtaining utilization review and the criteria used by a utilization review organization to make an authorization or adverse determination. If a health benefit plan includes utilization review requirements, the health plan company must have a process for conducting utilization review and must provide enrollees with a clear, concise description of the utilization review process in the enrollee's policy, contract, or certificate of coverage. (Minn. Stat. § 62M.04, subd. 1)

A utilization review organization's prior authorization requirements and restrictions, including clinical criteria used to make an authorization or adverse determination, must be posted on the public websites of the health plan companies that use the utilization review organization. For utilization review determinations other than prior authorization, a utilization review organization must, upon request, provide the criteria used to perform utilization review and the database, treatment guideline, or other basis for the criteria to an enrollee, provider, or the commissioner of commerce. (Minn. Stat. § 62M.10, subd. 7)

Written Procedures and Clinical Criteria

Utilization review organizations must have written procedures for conducting reviews, for providing notice of authorizations and adverse determinations, to address a provider's or enrollee's failure to provide the information needed to make a determination, and for appeals. Additionally, written clinical criteria must be used, as needed, to determine whether a request should be authorized. Actively practicing physicians must be involved in the development of clinical criteria and review procedures, and the clinical criteria must be evaluated and updated at least annually. Written documentation of a quality assessment program must also be maintained. Finally, utilization review organizations must have written procedures to ensure patient-specific information obtained during utilization review is kept confidential, used only for the purposes authorized in law, and shared only with individuals and organizations authorized to receive the information. (Minn. Stat. §§ 62M.05, subds. 1, 3, 4; 62M.06, subd. 1; 62M.09, subds. 5, 8; 62M.08, subd. 1)

Access to Staff; Review Procedures

A utilization review organization must provide access to its review staff by telephone during normal business hours and must have procedures for receiving calls after hours. Utilization review and hospital communications must be conducted during normal business hours unless otherwise agreed to. On-site reviews must be scheduled at least one business day in advance when possible. When performing on-site reviews, utilization review organization staff must carry certain identification and, if requested, must review medical records in designated areas. (Minn. Stat. § 62M.10, subds. 1-4)

Information Used to Conduct Utilization Review

In general, a utilization review organization may collect only the information needed to authorize an admission, procedure, or length of stay. Section 62M.04, subdivision 3, lists the

data a utilization review organization may collect from a health care provider to perform utilization review, and the organization may request additional information when there is a significant disagreement between the organization and the provider regarding the outcome of the review or appeal.

A utilization review organization cannot routinely request copies of medical records for all patients subject to review but instead must adhere to the following:

- For prospective and concurrent review conducted before or during a patient's inpatient stay, a utilization review organization should request copies of the pertinent portions of a patient's medical record only if there are difficulties authorizing the admission or extension of stay. This provision limits the medical records a utilization review organization may request to those needed to authorize the admission or extension of stay, and which records are necessary depends on the health condition and the treatment or service requested by the health care provider.

- A utilization review organization may retrospectively request copies of patient medical records for purposes such as auditing the services provided, quality assurance review, ensuring compliance with the health plan or provider contract, and compliance with utilization review.

(Minn. Stat. § 62M.04, subds. 2-4)

Standard Review and Expedited Review

There are two utilization review processes: expedited review and standard review. The type of review used determines the timeline within which the utilization review organization must provide notice of its determination to the affected enrollee, health care provider, and hospital or clinic.

A utilization review organization must use ***expedited review*** if the enrollee's health care provider believes an expedited determination is needed, and for prior authorizations for medications used for outpatient mental health treatment, outpatient substance use disorder treatment, or antineoplastic cancer treatment. Following expedited review, notification of a determination must be provided to the hospital, health care provider, and enrollee as expeditiously as the enrollee's medical condition requires but no later than 48 hours after the request. This 48-hour period must include at least one business day. (Minn. Stat. § 62M.05, subd. 3b)

If ***standard review*** is used, notification of a determination must be provided to the hospital or physician's office, health care provider, and enrollee within five business days after receipt of the request, as long as the utilization review organization has been provided with all information reasonably needed to make the determination. For authorizations, a utilization review organization must promptly communicate notice by telephone to the provider. Written notification of the authorization must also be sent to the provider, communicated by facsimile or e-mail, or maintained with an audit trail of the telephone notification. If an adverse determination is made, notice must be provided by telephone, facsimile, or e-mail to the

enrollee, health care provider, and hospital or physician office, with written notice also provided if the notice was provided by telephone. A written notification of an adverse determination must include all of the reasons relied on to make the adverse determination and the process for initiating an appeal. (Minn. Stat. § 62M.05, subd. 3a)

Appeals

If a utilization review organization issues an adverse determination, an enrollee or health care provider may appeal that determination. Utilization review organizations must establish procedures for appeals, and these procedures may specify a time period within which an appeal must be filed. As with determinations, there are two types of appeals in chapter 62M: expedited appeals and standard appeals. The type of appeal determines the time frame within which a decision on the appeal must be issued. In addition to these appeal processes, an enrollee may also file a complaint with the commissioner responsible for regulating the utilization review organization.

An ***expedited appeal*** is available when an adverse determination is made before a health care service is provided or during an ongoing service, and when the health care provider believes an expedited appeal is necessary. The expedited appeal process may also be used to appeal adverse determinations of prior authorization requests for medications for outpatient mental health treatment, outpatient substance use disorder treatment, or antineoplastic cancer treatment. An expedited appeal may be made by telephone, and notice of a decision on the expedited appeal must be provided to the enrollee and health care provider as expeditiously as the enrollee's medical condition requires but no later than 72 hours after the utilization review organization receives the appeal. (Minn. Stat. § 62M.06, subd. 2)

For a ***standard appeal***, the utilization review organization must notify the enrollee, health care provider, and claims administrator in writing of its decision on the appeal within 15 days after receiving the notice of appeal. A utilization review organization may take up to four additional days to issue its decision if it cannot issue the decision within the 15-day time period due to circumstances outside its control. If the utilization review organization takes any days beyond the 15-day time period to issue its decision, it must inform the enrollee, health care provider, and claims administrator in advance of the extension and the reasons for the extension. (Minn. Stat. § 62M.06, subd. 3) If an adverse determination is upheld, certain information must be provided to the health care provider or enrollee, including the right to appeal the determination using an external review process under section 62Q.73. External review is performed by a private entity under contract with the state.

A patient may also file a complaint regarding an adverse determination directly with the commissioner responsible for regulating the utilization review organization that issued the adverse determination. (Minn. Stat. § 62M.11) The applicable commissioner must review the complaint to determine whether the utilization review organization's determination complied with applicable laws and with the terms of the enrollee's health plan. Following an investigation, department staff may refer the complaint for enforcement action such as a monetary penalty or a corrective action plan.

The following table specifies timelines within which a notice of determination must be provided following utilization review and appeals of adverse determinations.

Type of Review or Appeal	Applicable Statute	Time Frame for Notice of Determination
Expedited review	§ 62M.05, subd. 3b	As expeditiously as enrollee's medical condition requires but no later than 48 hours after request; this 48-hour period must include at least one business day
Standard review	§ 62M.05, subd. 3a	Within five business days after receipt of request
Expedited appeal	§ 62M.06, subd. 2	As expeditiously as enrollee's medical condition requires but no later than 72 hours after receiving appeal
Standard appeal	§ 62M.06, subd. 3	Within 15 days after receiving notice of appeal, with up to four additional days if needed

Other Provisions

Chapter 62M also contains provisions governing the qualifications of utilization review organization staff conducting utilization reviews and prohibiting financial incentives for individuals conducting utilization reviews.

Staff Qualifications

Health care providers conducting reviews of medical services as part of the utilization review process must be licensed or certified in the United States. A utilization review organization must have certain health care providers make certain utilization review decisions. Physicians, pharmacists, dentists, and chiropractors must review cases or appeals relating to their areas of professional expertise. Specific requirements also exist for the personnel authorized to review adverse determinations for outpatient mental health or substance abuse services. (Minn. Stat. § 62M.09, subds. 1-4a, 6)

Inappropriate Incentives Prohibited

Individuals performing utilization review cannot receive financial incentives based on the number of adverse determinations they make. However, utilization review organizations may establish performance standards that are medically appropriate. (Minn. Stat. § 62M.12)

Appendix: Recent Changes to Chapter 62M

2020 Amendments to Chapter 62M

Numerous changes were made to chapter 62M in Laws 2020, chapter 114. These amendments included modifications to terms used for utilization review determinations, changes to timelines for utilization review determinations, establishment of additional prior authorization requirements, and changes to the qualifications of health care providers who make adverse determinations. A range of technical and conforming changes were also made.

Terms used for utilization review determinations were modified and made consistent. The term for a determination in which a health plan company covers an admission, extension of stay in a health care facility, or other health care service was changed from "certification" to "authorization," and the term for a determination that is partially or wholly adverse to the enrollee was changed from "determination not to certify," "denial of certification," or a similar term to "adverse determination."

This act shortened the times within which utilization review determinations and determinations on appeals must be communicated to enrollees and health care providers, from ten business days to five business days for standard review determinations; from 72 hours to 48 hours, including at least one business day, for expedited review determinations; and from 30 days plus 14 additional days, if needed, to 15 days plus four additional days, if needed, for standard appeals.

Additional requirements governing prior authorization were established. First, utilization review organizations and health plan companies are prohibited from revoking or limiting a prior authorization after it is authorized, except in limited circumstances. Health plan companies are also required to post applicable prior authorization requirements and restrictions on their public websites, along with data on prior authorization requests for the previous calendar year. In addition, enrollees must be provided with notice before a prior authorization requirement or restriction is added or modified. Finally, language was added to provide continuity of care for enrollees who have a prior authorization in effect, if the enrollee changes health plan companies or if a utilization review organization, during a plan year, changes coverage terms for a health care service or changes clinical criteria.

Modifications were also made to the qualification requirements for health care providers making adverse determinations for utilization review organizations. Physician reviewers must hold a current, unrestricted Minnesota license to practice medicine and must be in a medical specialty similar to the specialty that usually treats the condition for which the health care service was requested. Additionally, reviews involving a prescription drug must be conducted by either a licensed pharmacist or a physician able to evaluate the clinical issues presented.

These changes became effective January 1, 2021, for health plans offered, sold, issued, or renewed on or after that date.

2024 Amendments to Chapter 62M

Chapter 62M was amended in Laws 2024, chapter 127, articles 55 and 57. Changes in this act include extending chapter 62M to services delivered under chapters 256B (Medical Assistance) and 256L (MinnesotaCare), exempting certain services from prior authorization requirements, providing that authorizations for treatments of a chronic condition do not expire except in certain circumstances, requiring implementation of a prior authorization application programming interface, and requiring annual reports to the commissioner of health on prior authorizations.

Effective January 1, 2026, chapter 62M applies to managed care plans and county-based purchasing plans covering enrollees under chapter 256B or chapter 256L, and certain sections in chapter 62M apply to services delivered under fee-for-service under chapter 256B or 256L. Definitions and other provisions were amended to make them applicable to the commissioner of human services when performing utilization review for public health care program fee-for-service recipients.

Additional services were exempted from prior authorization requirements, and prior authorizations for medications for outpatient mental health treatment, outpatient substance use disorder treatment, and antineoplastic cancer treatment were required to be processed according to expedited processes for initial determinations and appeals. Language was also added to provide that an authorization for treatment of a chronic health condition does not expire unless the standard of treatment for the health condition changes. These changes are also effective January 1, 2026.

Effective January 1, 2027, utilization review organizations, health plan companies, and claims administrators must have a prior authorization application programming interface that automates the prior authorization process for health care services other than medications.

Utilization review organizations must report to the commissioner of health, on an annual basis, specified information on prior authorization requests for the previous calendar year.

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