

MAINE STATE LEGISLATURE

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114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document

No. 998

S.P. 374

In Senate, March 30, 1989

Reference to the Committee on Banking and Insurance suggested and ordered printed.

Joy J. O'Brien

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator MATTHEWS of Kennebec.

Cosponsored by Representative BURKE of Vassalboro, Representative PINES of Limestone and Senator RANDALL of Washington.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act to Register 3rd-party Medical Reimbursement Review Entities.



1 Be it enacted by the People of the State of Maine as follows:

3 Sec. 1. 24 MRSA §§2342 to 2344 are enacted to read:

5 §2342. Review entities

7 1. Registration. Any person, partnership or corporation,
9 other than an insurer or nonprofit service organization, that
11 performs medical utilization review services on behalf of
13 insurers, nonprofit service organizations or employers, shall
register with the Bureau of Insurance and pay an annual
registration fee of \$100. The Bureau of Insurance shall, by
rule, establish criteria for the registration.

15 2. Listing. The Bureau of Insurance shall compile and
17 maintain a current listing of persons, partnerships or
corporations registering pursuant to this section.

19 3. Information required. Each person, partnership or
21 corporation registering pursuant to this section shall, at the
23 time of initial registration and on or before April 1st of each
succeeding year, provide the Bureau of Insurance with the
following information:

25 A. The names and addresses of any insurers, nonprofit
27 service organizations or employers with which the entity
has contracted to provide medical utilization review
29 services;

31 B. The process by which the entity carries out its
33 utilization review services, including the categories of
health care personnel that perform any activities coming
35 under the definition of utilization review and whether or
not these individuals are licensed in the State;

37 C. The process used by the entity for addressing
beneficiary or provider complaints;

39 D. The types of utilization review programs offered by the
41 entity, such as:

43 (1) Second opinion programs;

45 (2) Prehospital admission certification;

47 (3) Preinpatient service eligibility determination; or

49 (4) Concurrent hospital review to determine
appropriate length of stay; and

51 E. The process chosen by the entity to preserve
53 beneficiary confidentiality of medical information.

1 §2343. Authority of superintendent to adopt additional rules

3 The superintendent may issue rules regarding the operation
4 of entities required to register pursuant to section 2342.

5 §2344. Utilization review services

7
8 As used in this chapter, unless the context indicates
9 otherwise, "utilization review services" or "medical utilization
10 review services" means any program or process by which a person,
11 partnership or corporation, on behalf of an insurer, nonprofit
12 service organization or employer which is a payor for medical
13 services, seeks to review the utilization, appropriateness or
14 quality of medical services provided to a person whose medical
15 services are paid for, partially or entirely, by that insurer,
16 nonprofit service organization or employer. The terms include
17 these programs or processes whether they apply prospectively or
18 retrospectively to medical services. Utilization review
19 services include, but are not limited to, the following:

21 1. Second opinion programs. Second opinion programs;

23 2. Prehospital admission certification. Prehospital
24 admission certification;

25 3. Preinpatient service eligibility certification.
26 Preinpatient service eligibility certification; and

27 4. Concurrent hospital review. Concurrent hospital review
28 to determine appropriate length of stay.

30 Sec. 2. 24-A §§2750 to 2752 are enacted to read:

31 §2750. Review entities

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34 1. Registration. Any person, partnership or corporation,
35 other than an insurer or nonprofit service organization, that
36 performs medical utilization review services on behalf of
37 insurers, nonprofit service organizations or employers, shall
38 register with the Bureau of Insurance and pay an annual
39 registration fee of \$100. The Bureau of Insurance shall, by
40 rule, establish criteria for the registration.

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42 2. Listing. The Bureau of Insurance shall compile and
43 maintain a current listing of persons, partnerships or
44 corporations registering pursuant to this section.

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46 3. Information required. Each person, partnership or
47 corporation registering pursuant to this section shall, at the
48 time of initial registration and on or before April 1st of each
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1 succeeding year, provide the Bureau of Insurance with the
2 following information:

3
4 A. The names and addresses of any insurers, nonprofit
5 service organizations or employers with which the entity
6 has contracted to provide medical utilization review
7 services;

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9 B. The process by which the entity carries out its
10 utilization review services, including the categories of
11 health care personnel that perform any activities coming
12 under the definition of utilization review and whether or
13 not these individuals are licensed in the State;

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15 C. The process used by the entity for addressing
16 beneficiary or provider complaints;

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18 D. The types of utilization review programs offered by the
19 entity, such as:

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21 (1) Second opinion programs;

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23 (2) Prehospital admission certification;

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25 (3) Preinpatient service eligibility determination; or

26
27 (4) Concurrent hospital review to determine
28 appropriate length of stay; and

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30 E. The process chosen by the entity to preserve
31 beneficiary confidentiality of medical information.

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33 **§2751. Authority of superintendent to adopt additional rules**

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35 The superintendent may issue rules regarding the operation
36 of entities required to register pursuant to section 2750.

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38 **§2752. Utilization review services**

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40 As used in this chapter, unless the context indicates
41 otherwise, "utilization review services" or "medical utilization
42 review services" means any program or process by which a person,
43 partnership or corporation, on behalf of an insurer, nonprofit
44 service organization or employer which is a payor for medical
45 services, seeks to review the utilization, appropriateness or
46 quality of medical services provided to a person whose medical
47 services are paid for, partially or entirely, by that insurer,
48 nonprofit service organization or employer. The terms include
49 these programs or processes whether they apply prospectively or
50 retrospectively to medical services. Utilization review
51 services include, but are not limited to, the following:

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53 **1. Second opinion programs. Second opinion programs:**

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2. Prehospital admission certification. Prehospital admission certification;

3. Preinpatient service eligibility certification. Preinpatient service eligibility certification; and

4. Concurrent hospital review. Concurrent hospital review to determine appropriate length of stay.

Sec. 3. 24-A §§2846 to 2848 are enacted to read:

§2846. Review entities

1. Registration. Any person, partnership or corporation, other than an insurer or nonprofit service organization, that performs medical utilization review services on behalf of insurers, nonprofit service organizations or employers, shall register with the Bureau of Insurance and pay an annual registration fee of \$100. The Bureau of Insurance shall, by rule, establish criteria for the registration.

2. Listing. The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations registering pursuant to this section.

3. Information required. Each person, partnership or corporation registering pursuant to this section shall at the time of initial registration and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The names and addresses of any insurers, nonprofit service organizations or employers with which the entity has contracted to provide medical utilization review services;

B. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State;

C. The process used by the entity for addressing beneficiary or provider complaints;

D. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

1 (3) Preinpatient service eligibility determination; or

3 (4) Concurrent hospital review to determine
5 appropriate length of stay; and

7 E. The process chosen by the entity to preserve
9 beneficiary confidentiality of medical information.

11 §2847. Authority of superintendent to adopt additional rules

13 The superintendent may issue rules regarding the operation
15 of entities required to register pursuant to section 2846.

17 §2848. Utilization review services

19 As used in this chapter, unless the context indicates
21 otherwise, "utilization review services" or "medical utilization
23 review services" means any program or process by which a person,
25 partnership or corporation, on behalf of an insurer, nonprofit
27 service organization or employer which is a payor for medical
29 services, seeks to review the utilization, appropriateness or
31 quality of medical services provided to a person whose medical
33 services are paid for, partially or entirely, by that insurer,
35 nonprofit service organization or employer. The terms include
37 these programs or processes whether they apply prospectively or
39 retrospectively to medical services. Utilization review
41 services include, but are not limited to, the following:

43 1. Second opinion programs. Second opinion programs;

45 2. Prehospital admission certification. Prehospital
47 admission certification;

49 3. Preinpatient service eligibility certification.
51 Preinpatient service eligibility certification; and

4. Concurrent hospital review. Concurrent hospital review
to determine appropriate length of stay.

Sec. 4. 24-A §2850 is enacted to read:

§2850. Utilization review data

1. Report required. On or before April 1st of each year,
any insurer which issues a program or contract in this State
providing coverage for hospital care that contains a provision
whereby in nonemergency cases the insured is required to be
prospectively evaluated through a prehospital admission
certification, preinpatient service eligibility program or any
similar preutilization review or screening eligibility program
or any similar preutilization review or screening procedure

1 prior to the delivery of contemplated hospitalization, inpatient
3 or outpatient health care or medical services which are
5 prescribed or ordered by a duly licensed physician shall file a
report on the results of that evaluation for the preceding year
with the superintendent which shall contain the following:

7 A. The number and type of evaluations performed. For the
9 purposes of this section, the term "type of evaluations"
11 means the following preutilization review categories:
13 presurgical inpatient days; setting of medical service,
such as inpatient or outpatient services; and the number of
days of service;

15 B. The result of the evaluation, such as whether the
17 medical necessity of the level of service contemplated by
the patient's physician was agreed to or whether benefits
paid for the service were reduced by the insurer;

19 C. The number and result of any appeals by the patients or
21 their physicians as a result of initial review decisions to
23 reduce benefits for services as determined through
prospective evaluations; and

25 D. Any complaints filed in a court of competent
27 jurisdiction and served upon an insurer filing under this
29 section stating a cause of action against that insurer on
31 the basis of damages to patients alleged to have been
proximately caused by a delay, reduction or denial of
medical benefits by the insurer, as determined through
prospective evaluations, and the determination of liability
or other disposition of the complaint.

33 2. Residents. This section is applicable to evaluations,
35 appeals and complaints relating to residents of this State only.

37 3. Confidentiality. Any information provided pursuant to
this section shall not identify the patients.

STATEMENT OF FACT

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43 This bill requires companies performing medical utilization
45 review services to register with the Bureau of Insurance and to
47 report annually to the bureau the types of utilization review
49 services they are providing. These companies have multiplied in
51 the recent past and thousands of Maine residents have health
insurance plans through employers who utilize the services of
such companies. Many times the patients, or subscribers, are
not aware of the reviewing entity and may have to seek approval
for a particular medical procedure through an out-of-state 800
number. The medical provider is frequently put in the middle

1 and asked to furnish confidential medical information on the
2 patient when the patient has not signed an appropriate release
3 form authorizing disclosure.

5 The purpose of this bill is not to discourage such review,
6 but simply to require such entities to register with the Bureau
7 of Insurance so that patients or providers dealing with such
8 entities have a place to go in order to assure that the entity
9 is legitimate.

11 Section 10 of the bill clarifies a provision in existing
12 law requiring utilization review data to be filed with the
13 bureau. According to the bureau, there is some question as to
14 whether group health insurance contracts are subject to the
15 requirements regarding utilization review data that were imposed
16 on insurers in 1987 by the Legislature. Section 10 of this bill
17 makes clear that the same requirements apply to group health
insurance contracts.