114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

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S.P. 374 In Senate, March 30, 1989

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

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.

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

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

§2342. 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;

(3) Preinpatient service eligibility determination; or

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

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

§2343. Authority of superintendent to adopt additional rules

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

§2344. Utilization review services

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

1. Second opinion programs. Second opinion programs;

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

§2750. 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;

(3) Preinpatient service eligibility determination; or

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

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

§2751. Authority of superintendent to adopt additional rules

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

§2752. Utilization review services

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

1. Second opinion programs. Second opinion programs;

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;

(3) Preinpatient service eligibility determination; or

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

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

§2847. Authority of superintendent to adopt additional rules

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

§2848. Utilization review services

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

1. Second opinion programs. Second opinion programs;

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. 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

prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are 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:

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

B. The result of the evaluation, such as whether the 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;

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

D. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on 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.

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

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

STATEMENT OF FACT

This bill requires companies performing medical utilization review services to register with the Bureau of Insurance and to report annually to the bureau the types of utilization review services they are providing. These companies have multiplied in 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

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

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

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