

# MAINE STATE LEGISLATURE

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# 116th MAINE LEGISLATURE

FIRST REGULAR SESSION-1993

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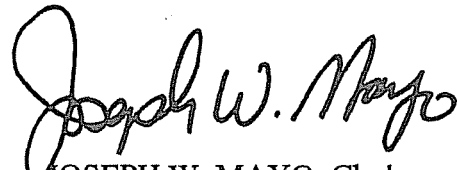
H.P. 789

House of Representatives, March 29, 1993

**An Act to Ensure Equitable Insurance Practices.**

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

  
JOSEPH W. MAYO, Clerk

Presented by Representative KILKELLY of Wiscasset.  
Cosponsored by Representatives: BOWERS of Washington, CARROLL of Gray, DAGGETT of  
Augusta, LARRIVÉE of Gorham, MORRISON of Bangor, PINEAU of Jay, Senators:  
HARRIMAN of Cumberland, PARADIS of Aroostook.

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

PART A

Sec. A-1. 24 MRSA §2342, sub-§1, as amended by PL 1989, c. 878, Pt. B, §21, is further amended to read:

1. **Licensure.** Any person, partnership or corporation, other than an insurer, or nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than \$400 and an annual license fee of not more than \$100. No A person, partnership or corporation, other than an insurer, or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

Sec. A-2. 24 MRSA §2342, sub-§3, ¶¶C and D, as enacted by PL 1989, c. 556, Pt. C, §1, are amended to read:

C. 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

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information; and

Sec. A-3. 24 MRSA §2342, sub-§3, ¶E is enacted to read:

E. A utilization review plan, including a description of the standards, criteria, policies, procedures and reasonable target periods governing utilization review activities.

Sec. A-4. 24 MRSA §2343, sub-§§5 and 6 are enacted to read:

2           **5. Prohibited activities.**    Requirements for medical  
utilization review programs include the following.

4           A. The applicant must ensure that the record of the entity  
6           performing the utilization review to determine need for  
            treatment or admission does not affect the compensation or  
            benefit paid to that entity.

8           B. If a course of treatment has been preauthorized or  
10           approved, the entity performing the utilization review may  
12           not revise the criteria or standards to reduce coverage for  
            the services delivered to the insured without the consent of  
            the insured and the provider.

14           C. A medical utilization review entity, its employees or  
16           paid advisors may not establish, operate or be affiliated  
18           with a substance abuse treatment facility or training  
            program.

20           D. If there is noncompliance with a medical utilization  
22           review program, penalties may not be applied and benefits  
24           for substance abuse treatment may not be reduced below the  
            minimum levels mandated by law. A group health insurance or  
26           health care contract, policy or certificate that does not  
            provide benefits above the minimum levels mandated by law  
            may not have penalties or reduced benefits for noncompliance  
            with the medical utilization review program.

28           E. A medical utilization review program may not define a  
30           medical emergency with respect to substance abuse more  
32           restrictively than the unexpected onset of a medical  
            condition that, if not treated immediately, could reasonably  
34           be expected to result in loss of life or serious impairment  
            of an individual's bodily functions.

36           **6. Emergency and nonemergency treatment and admission for**  
38           **substance abuse treatment.**    A medical utilization review program  
            must provide for emergency and nonemergency substance abuse  
            treatment and admission.

40           A. The program must provide for patient placement criteria  
42           that are consistent with the patient placement criteria  
44           published by the American Society of Addiction Medicine in  
            "Patient Placement Criteria for Treatment of Psychoactive  
            Substance Use Disorders."

46           B. The program must provide for treatment and admission if  
48           the treating provider determines the treatment or admission  
            to be necessary and the treating provider notifies the  
50           utilization review entity within 24 hours of the treatment

2 or admission. If the admission is for medical  
3 detoxification or treatment and is ordered by a physician  
4 licensed to practice in this State or in the state in which  
5 the provider is located and the physician certifies within  
6 72 hours of the admission or treatment that the insured  
7 person was in need of medical detoxification or treatment,  
8 the certification constitutes a prima facie case of medical  
9 necessity, which may be overcome by clear and convincing  
10 evidence that the admitted person was not in need of medical  
11 detoxification or treatment.

12 C. The program must provide a description of the procedures  
13 the medical utilization review entity will use to make  
14 decisions, including but not limited to the following.

16 (1) The medical utilization review entity shall assign  
17 a reasonable target review period for each admission or  
18 treatment promptly upon notification by the treating  
19 provider. At the end of the target review period, the  
20 medical utilization review entity shall review the need  
21 for inpatient or outpatient treatment.

22 (2) The medical utilization review entity may contact  
23 only those individuals designated by the treating  
24 provider for information.

26 (3) The medical utilization review entity may only  
27 review information relevant to the medical utilization  
28 review process and may not disclose or publish  
29 individual medical records or any confidential  
30 information obtained in the performance of medical  
31 utilization review activities.

34 (4) The medical utilization review entity must  
35 provide, upon the request of a treating provider, a  
36 medical utilization review decision within 24 hours of  
37 the request. A decision regarding continued treatment  
38 or admission must be communicated to the treating  
39 provider no less than one business day before the  
40 expiration of the previously approved treatment or  
41 admission period. A denial of continued treatment or  
42 admission must include an additional 72 hours of  
43 benefit coverage from the payor in order to effectuate  
44 the insured person's discharge.

46 (5) The medical utilization review entity may not make  
47 a decision adverse to an insured person or to any  
48 treating provider on any question relating to the  
49 necessity or justification for any form of hospital,  
50 medical or other substance abuse treatment service

2 unless there is prior evaluation and concurrence by a  
4 physician and the physician discusses the determination  
6 with the treating provider. The reasons for any  
8 adverse determination must be provided in writing to  
10 the treating provider within 3 business days of the  
12 determination and must be signed by the physician who  
14 made the determination.

16 (6) The treating provider may request and must receive  
18 within 24 hours of the request a 2nd opinion on any  
20 adverse determination. While the 2nd opinion is  
22 pending, benefits must be provided to the insured  
24 person.

26 D. The program must provide a description of an independent  
28 appeal procedure to be used in evaluating proposed or  
30 delivered substance abuse treatment services, which must  
32 include the following.

34 (1) The medical utilization review entity shall  
36 provide for independent 3rd-party review of an appeal  
38 of any adverse determination by the medical utilization  
40 review entity within 72 hours of the filing of the  
42 appeal, during which time benefits for ongoing  
44 treatment may not be denied.

46 (2) The appeal procedure must include an appeals  
48 board, composed of 3 qualified health professionals  
50 with experience in addiction medicine, as defined in  
rules adopted by the Bureau of Insurance. One member  
must be selected by the utilization review entity. One  
member must be selected by the insured person, a family  
member of the insured person or a treating provider.  
One member must be selected by agreement of the other 2  
members.

(3) All costs associated with the settlement of a  
dispute, including costs of treatment until resolution  
of the dispute, must be paid initially by the  
utilization review entity.

E. The program must include the names, addresses, telephone  
numbers and qualifications of the personnel who will be  
performing medical utilization review for substance abuse  
treatment services, including at least the following:

(1) For performing initial medical utilization review  
of substance abuse treatment services when information  
is necessary from a physician, treating provider or  
treatment facility to determine the medical necessity

2 or appropriateness of such services, a licensed  
3 practical nurse or licensed registered nurse with  
4 experience in addiction medicine or a health care  
5 professional, which may include a licensed substance  
6 abuse counselor or other qualified health professional,  
7 with experience in addiction medicine as defined in  
8 rules adopted by the Bureau of Insurance; and

9  
10 (2) For an initial determination of denial by the  
11 medical utilization review entity, a licensed physician  
12 who is actively practicing and who has demonstrated  
13 expertise in the field of addiction medicine. The  
14 determination of denial must be accompanied by the  
15 written findings and evaluation of the physician.

16 F. The program must include procedures to ensure that the  
17 medical utilization review entity will be readily accessible  
18 by telephone to the insured person and treating providers at  
19 least 40 hours per week during normal business hours. The  
20 program must provide a toll-free telephone line for insured  
21 persons and treating providers to contact the medical  
22 utilization review entity.

23  
24 G. The program must include procedures to ensure that the  
25 medical utilization review entity will respond by telephone  
26 to insured persons and treating providers within 4 business  
27 days of being contacted.

28  
29 H. The program must include procedures by which the medical  
30 utilization review entity will notify the insured person and  
31 the treating provider when payment for substance abuse  
32 treatment is denied or limited. The procedures must require  
33 a written statement for the denial or limitation.

34  
35 I. The program must include policies and procedures to  
36 ensure that all applicable state and federal laws that  
37 protect the confidentiality of individual medical records  
38 are followed.

39  
40 **Sec. A-5. 24 MRSA §2344, first ¶, as enacted by PL 1989, c.**  
41 **556, Pt. C, §1, is amended to read:**

42  
43 As used in this subchapter, unless the context indicates  
44 otherwise, "utilization review services" or "medical utilization  
45 review services" means any program or process by which a person,  
46 partnership or corporation, on behalf of an insurer, nonprofit  
47 service organization, 3rd-party administrator, health maintenance  
48 organization, preferred provider organization or employer which  
49 that is a payor for or which that arranges for payment of medical  
50 services, seeks to review the utilization, appropriateness or

2 quality of medical services provided to a person whose medical  
3 services are paid for, partially or entirely, by that insurer,  
4 nonprofit service organization, 3rd-party administrator, health  
5 maintenance organization, preferred provider organization or  
6 employer. The terms include these programs or processes whether  
7 they apply prospectively or retrospectively to medical services.  
8 Utilization review services include, but are not limited to, the  
9 following:

10 **Sec. A-6. 24 MRSA §2345, sub-§6** is enacted to read:

11 **6. Report.** The superintendent shall report on or before  
12 January 1, 1994 and January 1st of each even-numbered year  
13 thereafter to the joint standing committee of the Legislature  
14 having jurisdiction over banking and insurance matters on the  
15 performance of entities authorized under this chapter to perform  
16 utilization reviews.

17 **PART B**

18  
19  
20 **Sec. B-1. 24-A MRSA §2771, sub-§1**, as amended by PL 1989, c.  
21 878, Pt. B, §22, is further amended to read:

22  
23 **1. Licensure.** Any person, partnership or corporation,  
24 other than an insurer, or nonprofit service organization, health  
25 maintenance organization, preferred provider organization or  
26 employee of those exempt organizations, that performs medical  
27 utilization review services on behalf of commercial insurers,  
28 nonprofit service organizations, 3rd-party administrators, health  
29 maintenance organizations, preferred provider organizations or  
30 employers, shall apply for licensure by the Bureau of Insurance  
31 and pay an application fee of not more than \$400 and an annual  
32 license fee of not more than \$100. No A person, partnership or  
33 corporation, other than an insurer, or nonprofit service  
34 organization, health maintenance organization, preferred provider  
35 organization or the employees of exempt organizations, may not  
36 perform utilization review services or medical utilization review  
37 services unless the person, partnership or corporation has  
38 received a license to perform those activities.

39  
40 **Sec. B-2. 24-A MRSA §2771, sub-§3, ¶¶C and D**, as enacted by PL  
41 1989, c. 556, Pt. C, §2, are amended to read:

42  
43 **C.** The types of utilization review programs offered by the  
44 entity, such as:

- 45  
46 (1) Second opinion programs;  
47  
48 (2) Prehospital admission certification;  
49  
50



2 (3) Preinpatient service eligibility determination; or

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

6 D. The process chosen by the entity to preserve beneficiary  
confidentiality of medical information; and

8 **Sec. B-3. 24-A MRSA §2771, sub-§3, ¶E** is enacted to read:

10 E. A utilization review plan, including a description of  
12 the standards, criteria, policies, procedures and reasonable  
14 target periods governing utilization review activities.

16 **Sec. B-4. 24-A MRSA §2772, sub-§§5 and 6** are enacted to read:

18 **5. Prohibited activities.** Requirements for medical  
utilization review programs include the following.

20 A. The applicant must ensure that the record of the entity  
22 performing the utilization review to determine need for  
treatment or admission does not affect the compensation or  
24 benefit paid to that entity.

26 B. If a course of treatment has been preauthorized or  
approved, the entity performing the utilization review may  
28 not revise the criteria or standards to reduce insurance  
coverage for the services delivered to the insured without  
30 the consent of the insured and the provider.

32 C. A medical utilization review entity, its employees or  
paid advisors may not establish, operate or be affiliated  
34 with a substance abuse treatment facility or training  
program.

36 D. If there is noncompliance with a medical utilization  
review program, penalties may not be applied and benefits  
38 for substance abuse treatment may not be reduced below the  
minimum levels mandated by law. A group health insurance or  
40 health care contract, policy or certificate that does not  
42 provide benefits above the minimum levels mandated by law  
may not have penalties or reduced benefits for noncompliance  
44 with the medical utilization review program.

46 E. A medical utilization review program may not define a  
medical emergency with respect to substance abuse more  
48 restrictively than the unexpected onset of a medical  
condition that, if not treated immediately, could reasonably  
50 be expected to result in loss of life or serious impairment  
of an individual's bodily functions.

2           6. Emergency and nonemergency treatment and admission for  
3           substance abuse treatment. A medical utilization review program  
4           must provide for emergency and nonemergency substance abuse  
5           treatment and admission.

6  
7           A. The program must provide for patient placement criteria  
8           that are consistent with the patient placement criteria  
9           published by the American Society of Addiction Medicine in  
10           "Patient Placement Criteria for Treatment of Psychoactive  
11           Substance Use Disorders."

12  
13           B. The program must provide for treatment and admission if  
14           the treating provider determines the treatment or admission  
15           to be necessary and the treating provider notifies the  
16           utilization review entity within 24 hours of the treatment  
17           or admission. If the admission is for medical  
18           detoxification or treatment and is ordered by a physician  
19           licensed to practice in this State or in the state in which  
20           the provider is located and the physician certifies within  
21           72 hours of the admission or treatment that the insured  
22           person was in need of medical detoxification or treatment,  
23           the certification constitutes a prima facie case of medical  
24           necessity, which may be overcome by clear and convincing  
25           evidence that the admitted person was not in need of medical  
26           detoxification or treatment.

27  
28           C. The program must provide a description of the procedures  
29           the medical utilization review entity will use to make  
30           decisions, including but not limited to the following.

31  
32           (1) The medical utilization review entity shall assign  
33           a reasonable target review period for each admission or  
34           treatment promptly upon notification by the treating  
35           provider. At the end of the target review period, the  
36           medical utilization review entity shall review the need  
37           for inpatient or outpatient treatment.

38  
39           (2) The medical utilization review entity may contact  
40           only those individuals designated by the treating  
41           provider for information.

42  
43           (3) The medical utilization review entity may only  
44           review information relevant to the medical utilization  
45           review process and may not disclose or publish  
46           individual medical records or any confidential  
47           information obtained in the performance of medical  
48           utilization review activities.

2           (4) The medical utilization review entity must  
3           provide, upon the request of a treating provider, a  
4           medical utilization review decision within 24 hours of  
5           the request. A decision regarding continued treatment  
6           or admission must be communicated to the treating  
7           provider no less than one business day before the  
8           expiration of the previously approved treatment or  
9           admission period. A denial of continued treatment or  
10           admission must include an additional 72 hours of  
11           benefit coverage from the payor in order to effectuate  
12           the insured person's discharge.

13           (5) The medical utilization review entity may not make  
14           a decision adverse to an insured person or to any  
15           treating provider on any question relating to the  
16           necessity or justification for any form of hospital,  
17           medical or other substance abuse treatment service  
18           unless there is prior evaluation and concurrence by a  
19           physician and the physician discusses the determination  
20           with the treating provider. The reasons for any  
21           adverse determination must be provided in writing to  
22           the treating provider within 3 business days of the  
23           determination and must be signed by the physician who  
24           made the determination.

25           (6) The treating provider may request and must receive  
26           within 24 hours of the request a 2nd opinion on any  
27           adverse determination. While the 2nd opinion is  
28           pending, benefits must be provided to the insured  
29           person.

30  
31           D. The program must provide a description of an independent  
32           appeal procedure to be used in evaluating proposed or  
33           delivered substance abuse treatment services, which must  
34           include the following.

35           (1) The medical utilization review entity shall  
36           provide for independent 3rd-party review of an appeal  
37           of any adverse determination by the medical utilization  
38           review entity within 72 hours of the filing of the  
39           appeal, during which time benefits for ongoing  
40           treatment may not be denied.

41           (2) The appeal procedure must include an appeals  
42           board, composed of 3 qualified health professionals  
43           with experience in addiction medicine, as defined in  
44           rules adopted by the Bureau of Insurance. One member  
45           must be selected by the utilization review entity. One  
46           member must be selected by the insured person, a family  
47           member of the insured person or a treating provider.  
48  
49  
50

2                   One member must be selected by agreement of the other 2  
3                   members.

4                   (3) All costs associated with the settlement of a  
5                   dispute, including costs of treatment until resolution  
6                   of the dispute, must be paid initially by the  
7                   utilization review entity.

8

9                   E. The program must include the names, addresses, telephone  
10                   numbers and qualifications of the personnel who will be  
11                   performing medical utilization review for substance abuse  
12                   treatment services, including at least the following:

13

14                   (1) For performing initial medical utilization review  
15                   of substance abuse treatment services when information  
16                   is necessary from a physician, treating provider or  
17                   treatment facility to determine the medical necessity  
18                   or appropriateness of such services, a licensed  
19                   practical nurse or licensed registered nurse with  
20                   experience in addiction medicine or a health care  
21                   professional, which may include a licensed substance  
22                   abuse counselor or other qualified health professional,  
23                   with experience in addiction medicine as defined in  
24                   rules adopted by the Bureau of Insurance; and

25

26                   (2) For an initial determination of denial by the  
27                   medical utilization review entity, a licensed physician  
28                   who is actively practicing and who has demonstrated  
29                   expertise in the field of addiction medicine. The  
30                   determination of denial must be accompanied by the  
31                   written findings and evaluation of the physician.

32

33                   F. The program must include procedures to ensure that the  
34                   medical utilization review entity will be readily accessible  
35                   by telephone to the insured person and treating providers at  
36                   least 40 hours per week during normal business hours. The  
37                   program must provide a toll-free telephone line for insured  
38                   persons and treating providers to contact the medical  
39                   utilization review entity.

40

41                   G. The program must include procedures to ensure that the  
42                   medical utilization review entity will respond by telephone  
43                   to insured persons and treating providers within 4 business  
44                   days of being contacted.

45

46                   H. The program must include procedures by which the medical  
47                   utilization review entity will notify the insured person and  
48                   the treating provider when payment for substance abuse  
49                   treatment is denied or limited. The procedures must require  
50                   a written statement for the denial or limitation.

2 I. The program must include policies and procedures to  
4 ensure that all applicable state and federal laws that  
6 protect the confidentiality of individual medical records  
8 are followed.

10 **Sec. B-5. 24-A MRSA §2773, first ¶,** as enacted by PL 1989, c.  
12 556, Pt. C, §2, is amended to read:

14 As used in this chapter, unless the context indicates  
16 otherwise, "utilization review services" or "medical utilization  
18 review services" means any program or process by which a person,  
20 partnership or corporation, on behalf of an insurer, nonprofit  
22 service organization, 3rd-party administrator, health maintenance  
24 organization, preferred provider organization or employer which  
26 that is a payor for or which that arranges for payment of 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, 3rd-party administrator, health  
maintenance organization, preferred provider 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:

28 **Sec. B-6. 24-A MRSA §2774, sub-§6** is enacted to read:

30 **6. Report.** The superintendent shall report on or before  
32 January 1, 1994 and January 1st of each even-numbered year  
34 thereafter to the joint standing committee of the Legislature  
having jurisdiction over banking and insurance matters on the  
performance of entities authorized under this chapter to perform  
utilization reviews.

## 36 STATEMENT OF FACT

38 This bill extends the medical utilization review  
40 requirements to health maintenance organizations and preferred  
42 provider organizations.

44 This bill requires entities applying for licenses to perform  
46 medical utilization reviews, under which there are prospective  
48 evaluations of hospitalization, services or care, continued stay  
50 reviews, discharge planning and concurrent reviews, to submit  
utilization review plans with their applications in accordance  
with the Maine Revised Statutes, Titles 24 and 24-A. The bill  
prohibits any connection between the pay of the entity performing  
the review and that entity's record of determining need for

2 treatment or admission. It prohibits utilization review  
3 entities, their employees and paid advisors from establishing,  
4 operating or being affiliated with their own substance abuse  
treatment facilities or training programs.

6 The bill requires that the utilization review plans contain  
7 provisions for emergency and nonemergency treatment and  
8 admissions, including patient placement criteria published by the  
9 American Society of Addiction Medicine and emergency treatment  
10 and admission if the treating provider determines the treatment  
11 or admission to be medically necessary and notifies the  
12 utilization review entity within 24 hours. If the admission is  
13 for medical detoxification or treatment, there is a presumption  
14 of medical necessity of the admission. The bill specifies  
15 requirements of the medical utilization review program, including  
16 details on decision procedures, appeal procedures, identification  
17 of personnel, availability by telephone, response obligations,  
18 notification procedures and compliance with state and federal  
19 law.

20 The bill requires a report from the Superintendent of  
21 Insurance to the Joint Standing Committee on Banking and  
22 Insurance on or before January 1, 1994 and January 1st of each  
23 even-numbered year thereafter on the performance of entities  
24 authorized to perform utilization reviews under Titles 24 and  
25 24-A.  
26