MAINE STATE LEGISLATURE

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116th MAINE LEGISLATURE

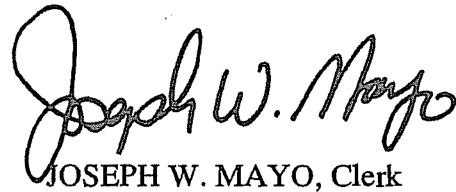
FIRST REGULAR SESSION-1993

Legislative Document **No. 1062**

H.P. 789 House of Representatives, March 29, 1993

An Act to Ensure Equitable Insurance Practices.

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, LARRIVEE of Gorham, MORRISON of Bangor, PINEAU of Jay, Senators: HARRIMAN of Cumberland, PARADIS of Aroostook.

Printed on recycled paper

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 performing the utilization review to determine need for
6 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 not revise the criteria or standards to reduce coverage for
12 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 with a substance abuse treatment facility or training
18 program.

20 D. If there is noncompliance with a medical utilization review program, penalties may not be applied and benefits
22 for substance abuse treatment may not be reduced below the minimum levels mandated by law. A group health insurance or
24 health care contract, policy or certificate that does not provide benefits above the minimum levels mandated by law
26 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 restrictively than the unexpected onset of a medical
32 condition that, if not treated immediately, could reasonably be expected to result in loss of life or serious impairment
34 of an individual's bodily functions.

36 **6. Emergency and nonemergency treatment and admission for substance abuse treatment.** A medical utilization review program
38 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 published by the American Society of Addiction Medicine in
44 "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

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

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

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

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

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

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

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

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

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

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

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

(2) The appeal procedure must include an appeals board, composed of 3 qualified health professionals 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

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

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

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

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

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

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

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

As used in this subchapter, 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, 3rd-party administrator, health maintenance organization, preferred provider organization or employer ~~which~~ 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:

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

6. Report. The superintendent shall report on or before January 1, 1994 and January 1st of each even-numbered year 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.

PART B

Sec. B-1. 24-A MRSA §2771, sub-§1, as amended by PL 1989, c. 878, Pt. B, §22, 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 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. B-2. 24-A MRSA §2771, sub-§3, ¶¶C and D, as enacted by PL 1989, c. 556, Pt. C, §2, 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. B-3. 24-A MRSA §2771, 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. B-4. 24-A MRSA §2772, sub-§§5 and 6 are enacted to read:

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

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

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

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

D. If there is noncompliance with a medical utilization review program, penalties may not be applied and benefits for substance abuse treatment may not be reduced below the minimum levels mandated by law. A group health insurance or 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.

E. A medical utilization review program may not define a medical emergency with respect to substance abuse more restrictively than the unexpected onset of a medical condition that, if not treated immediately, could reasonably 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 substance abuse treatment.** A medical utilization review program
4 must provide for emergency and nonemergency substance abuse treatment and admission.

6

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

12

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

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

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

38

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

42

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

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

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

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

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

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

(2) The appeal procedure must include an appeals board, composed of 3 qualified health professionals 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 or appropriateness of such services, a licensed practical nurse or licensed registered nurse with experience in addiction medicine or a health care professional, which may include a licensed substance abuse counselor or other qualified health professional, with experience in addiction medicine as defined in rules adopted by the Bureau of Insurance; and

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

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

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

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

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

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

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, 3rd-party administrator, health maintenance organization, preferred provider organization or employer ~~which~~ 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:

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

6. Report. The superintendent shall report on or before January 1, 1994 and January 1st of each even-numbered year 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.

STATEMENT OF FACT

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

This bill requires entities applying for licenses to perform medical utilization reviews, under which there are prospective evaluations of hospitalization, services or care, continued stay 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

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

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

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