Overview

This bill makes a number of changes to Minnesota Statutes, chapters 62M and 62Q and creates an external appeal process.

1 (62D.11, subd. 1.) makes conforming changes.

-30230 Deal with chapter 62M. A number of these sections are minor in nature and simply attempt to cleanup and update the language of this chapter.

2 (62M.01) Adds community integrated service networks (CISNs) and accountable provider networks to the jurisdiction of chapter 62M and clarifies that the appeal procedure of chapter 62M must be used for any complaint under chapter 62Q that requires a medical determination in its resolution.

3-17 Make a number of minor changes. The use of patient is changed to enrollee. References to attending physician are changed to attending health care professionals. References to health carrier are changed to health plan company (HPC). Provides an updated definition of "enrollee" in section 10. Provides a definition of "health plan company." Includes references to CISNs and accountable provider networks.

18 (62M.04) Requires an HPC to provide a clear and concise description of the utilization review process to each enrollee as part of the policy, subscriber contract, or certificate of coverage.

19-21 Make technical changes by changing references to health plan company and to attending health care professional.

22 (62M.05) Deletes reference to section 72A.201, subdivision 4a. Requires a utilization review organization (URO) to make an initial determination on all requests for utilization review within ten days of the request provided that all information reasonably necessary to make a decision has been made available to the URO. (This requirement is not new).

When an initial determination is made not to certify, the URO must notify the attending health care professional and hospital within one working day after making the determination, and
written notification must be sent to the hospital, attending health care professional, and the enrollee. This written notification must inform the enrollee and attending health care professional that they have the right to appeal the determination to the external appeal process or to the URO's internal appeal process. (This is not new except for the notification of the right to go to the external appeal process.)

Also adds an expedited initial review determination. (This is new.) If the attending health care professional believes that an expedited determination is warranted, the URO must make a determination and notify the enrollee, attending health care professional, and hospital as expeditiously as the enrollee's medical condition requires but no later than 72 hours from the initial request. If the expedited initial determination is made not to certify, the URO is required to notify the enrollee and attending health care professional of the right to submit an appeal to the external appeal process or to the URO's expedited internal appeal process.

Also requires the URO to forward a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan if the URO and claims administrator are separate entities.

23  (62M.06) Describes the expedited and standard internal appeal process. The URO is required to notify the enrollee and attending health care professional by telephone of its determination on an expedited appeal as expeditiously as the enrollee's medical condition requires but no later than 72 hours after receiving the appeal. (The notification time is new, but the expedited appeal is not). If the determination is not reversed through the expedited appeal, the URO is required to notify the enrollee and health care professional of the right to submit the appeal to the external appeal process. The URO is required to notify the enrollee and attending health care professional of its determination on a standard appeal within 30 days of receipt of the notice of appeal. If the initial determination is not reversed on appeal, the URO is required to provide notification of the right to submit the appeal to the external appeal process. (Currently, the URO has 45 days to decide the standard appeal.)

23  **Subd. 3a.** Permits the URO to establish a second internal appeals process if the determination not to certify is not reversed through the standard appeal. The enrollee is not required to exhaust this second appeal before submitting an appeal to the external appeal process. (This is new.)

24-32  Make minor changes by changing internal statutory references and changes the reference to attending health care professionals.

33-38  Deal with chapter 62Q. Most of the complaint process described in these sections are current requirements for HMOs.

33  (62Q.68) Defines complaints and complainants. The definition of complaints specifies that any grievance requiring a medical determination in its resolution must be processed under the appeal procedure of chapter 62M.

34  (62Q.69) Describes the procedures for submitting a complaint. Allows a complaint to be made either by telephone or in writing. If a complaint is made by telephone and the resolution of the complaint is partially or wholly adverse to the complainant or is not resolved within ten days, the health plan company is required to inform the complainant that a complaint may be submitted in writing and must promptly mail out a complaint form. The health plan company must notify the complainant in writing of its decision as soon as practical but not later than 30 days after receipt of the written complaint. If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the external appeal process or to the internal appeal process. The notification must also inform the complainant of the complainant's right to submit the complaint to the Commissioner of Health or Commerce at any time.

35  (62Q.70) Describes the appeal process. Requires the health plan company to provide the
complainant the option of having the appeal heard by hearing or in writing. Written notice of the appeal decision must be provided to the complainant within 30 days of receipt of the notice of appeal. If the decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the decision to the external appeal process. (Currently, HMOs have 30 days to decide an appeal that has been submitted by writing and 45 days if the appeal is by a hearing.)

36 (62Q.71) Describes what a health plan company must provide to an enrollee in terms of the complaint process as part of the member handbook, subscriber contract, or certificate of coverage.

37 (62Q.72) Requires the health plan company to maintain records of all enrollee complaints and their resolutions. These records must be maintained for five years and must be made available to the commissioner upon request.

38 (62Q.73) Describes the external process.

Subd. 1. Defines an adverse determination.

Subd. 2. Permits any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination to submit a written request for an external appeal to the commissioner. Requires the health plan company to participate in the external process.

Subd. 3. Requires the commissioner, pursuant to a request for proposal, to contract with an organization or business entity to provide external reviews.

Subd. 4. Provides criteria for the request for proposals.

Subd. 5. Requires the external review entity to notify the enrollee and health plan company upon receiving a request for an external appeal. Within ten days of receiving notice of the appeal, the health plan company and enrollee must provide the external review entity with any information that they wish to considered. Each party shall be provided the opportunity to present its version of the facts and arguments. The enrollee may be assisted or represented by a person of the enrollee's choice. The external review entity must make a decision as soon as practical but no later than 40 days after receiving the request for an external review (30 days plus the ten days given to the parties to submit information) and must promptly send written notice of the decision and the reasons for it to the parties.

Subd. 6. States that the decision by the external review entity is nonbinding on the enrollee and binding on the health plan company but allows a health plan company to seek judicial review if the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 7. Provides immunity from civil liability to any person who participates in an external appeal if the action taken was in good faith and within the scope of the person's duties and does not constitute willful or reckless misconduct.

Subd. 8. Permits the commissioner to award attorney fees to the enrollee if the commissioner determines such an award is warranted.

Subd. 9. States that any medical record provided for purposes of an external appeal shall remain confidential and shall be used only for the purpose of rendering a decision.

Subd. 10. Requires the external review entity to provide the commissioner with the number of reviews heard and a summary of each decision. Also requires the commissioners to make available to the public, upon request, summary data on the decisions rendered under this section, including the number of appeals heard and the final outcomes.

Make conforming changes to sections 62T.04, 72A.201, and 256B.692 in accordance with the changes to chapters 62M and 62Q.

43 Appropriates money for the purpose of establishing and operating the joint interagency.
Repeals the sections and rules that are no longer needed or incorporated in the new language.