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SENATE BILL NO. 447

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INTRODUCED BY V. RICCI, C. SCHOMER, C. HINKLE, J. ETCHART, L. DEMING, J. KARLEN

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4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATED TO PRIOR AUTHORIZATION;  
5 EXTENDING THE LENGTH OF A PRIOR AUTHORIZATION CERTIFICATION; PROVIDING THAT A PRIOR  
6 AUTHORIZATION FOR TREATMENT OF A CHRONIC CONDITION IS VALID FOR THE DURATION OF THE  
7 CONDITION; PROHIBITING PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTIONS; PROVIDING  
8 DEFINITIONS; AND AMENDING SECTIONS 33-32-102, 33-32-107, AND 33-32-221, MCA."

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10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

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12 **Section 1.** Section 33-32-102, MCA, is amended to read:

13 **"33-32-102. Definitions.** As used in this chapter, the following definitions apply:

14 (1) "Adverse determination", except as provided in 33-32-402, means:

15 (a) a determination by a health insurance issuer or its designated utilization review organization  
16 that, based on the provided information and after application of any utilization review technique, a requested  
17 benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not  
18 made in whole or in part for the requested benefit because the requested benefit does not meet the health  
19 insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level  
20 of effectiveness or is determined to be experimental or investigational;

21 (b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a  
22 requested benefit based on a determination by a health insurance issuer or its designated utilization review  
23 organization of a person's eligibility to participate in the health insurance issuer's health plan;

24 (c) any prospective review or retrospective review of a benefit determination that denies, reduces,  
25 or terminates or fails to provide or make payment in whole or in part for a benefit; or

26 (d) a rescission of coverage determination.

27 (2) "Ambulatory review" means a utilization review of health care services performed or provided in  
28 an outpatient setting.

1 (3) "Authorized representative" means:

2 (a) a person to whom a covered person has given express written consent to represent the  
3 covered person;

4 (b) a person authorized by law to provide substituted consent for a covered person; or  
5 (c) a family member of the covered person, or the covered person's treating health care  
6 only if the covered person is unable to provide consent.

7 (4) "Case management" means a coordinated set of activities conducted for individual patient  
8 management of serious, complicated, protracted, or otherwise complex health conditions.

13        (6)      "Chronic condition" means a condition that lasts 1 year or more and requires ongoing medical  
14      attention or limits activities of daily living.

15 (6)(7) "Clinical peer" means a physician or other health care provider who:

16 (a) holds a nonrestricted license in a state of the United States; and

17 (b) is trained or works in the same or a similar specialty to the specialty that typically manages the  
18 medical condition, procedure, or treatment under review.

19           (7)(8) "Clinical review criteria" means the written policies, written screening procedures, decision  
20           abstracts, determination rules, clinical and medical protocols, practice guidelines, or any other criteria or  
21           rationale used by a health insurance issuer or its designated utilization review organization to determine the  
22           medical necessity of health care services.

23                   (8)(9) "Concurrent review" means a utilization review conducted during a patient's stay or course of  
24 treatment in a facility, the office of a health care professional, or another inpatient or outpatient health care  
25 setting.

26                   (9)(10) "Cost sharing" means the share of costs that a covered member pays under the health  
27 insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or  
28 similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the

1 cost of noncovered services.

2 (10)(11)"Covered benefits" or "benefits" means those health care services to which a covered person is  
3 entitled under the terms of a health plan.

4 (11)(12)"Covered person" means a policyholder, a certificate holder, a member, a subscriber, an  
5 enrollee, or another individual participating in a health plan.

6 (12)(13)"Discharge planning" means the formal process for determining, prior to discharge from a  
7 facility, the coordination and management of the care that a patient receives after discharge from a facility.

8 (13)(14)"Emergency medical condition" has the meaning provided in 33-36-103.

9 (14)(15)"Emergency services" has the meaning provided in 33-36-103.

10 (15)(16)"External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.

11 (16)(17)"Final adverse determination" means an adverse determination involving a covered benefit that  
12 has been upheld by a health insurance issuer or its designated utilization review organization at the completion  
13 of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.

14 (17)(18)"Grievance" means a written complaint or an oral complaint if the complaint involves an urgent  
15 care request submitted by or on behalf of a covered person regarding:

16 (a) availability, delivery, or quality of health care services, including a complaint regarding an  
17 adverse determination made pursuant to utilization review;

18 (b) claims payment, handling, or reimbursement for health care services; or

19 (c) matters pertaining to the contractual relationship between a covered person and a health  
20 insurance issuer.

21 (18)(19)"Health care provider" or "provider" means a person, corporation, facility, or institution licensed  
22 by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:

23 (a) a physician, physician assistant, advanced practice registered nurse, health care facility as  
24 defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist,  
25 psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed  
26 professional counselor; and

27 (b) an officer, employee, or agent of a person described in subsection (18)(a)-(19)(a) acting in the  
28 course and scope of employment.

1           (19)(20)"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of  
2   a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or  
3   durable medical equipment.

4           (20)(21)"Health insurance issuer" has the meaning provided in 33-22-140.

5           (21)(22)"Medical necessity" means health care services that a health care provider exercising prudent  
6   clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating,  
7   curing, or relieving a health condition, chronic condition, illness, injury, or disease or its symptoms or  
8   comorbidities, including minimizing the progression, symptoms, or comorbidities of a health condition, chronic  
9   condition, illness, injury, or disease, and that are:

10          (a)    in accordance with generally accepted standards of practice;

11          (b)    clinically appropriate in terms of type, frequency, extent, site, and duration and are considered  
12   effective for the patient's illness, injury, or disease; and

13          (c)    not primarily for the economic benefit of the insurer or convenience of the patient or health care  
14   provider and not more costly than an alternative service or sequence of services at least as likely to produce  
15   equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or  
16   disease.

17           (22)(23)"Network" means the group of participating providers providing services to a managed care  
18   plan.

19           (23)(24)"Participating provider" means a health care provider who, under a contract with a health  
20   insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered  
21   persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly  
22   or indirectly from the health insurance issuer.

23           (24)(25)"Person" means an individual, a corporation, a partnership, an association, a joint venture, a  
24   joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in  
25   this subsection.

26           (25)(26)"Preservice claim" means a request for benefits or payment from a health insurance issuer for  
27   health care services that, under the terms of the health insurance issuer's contract of coverage, requires  
28   authorization from the health insurance issuer or from the health insurance issuer's designated utilization review

1 organization prior to receiving the services.

2 (26)(27)"Prospective review" means a utilization review, MEDICAL NECESSITY REVIEW, OR PRIOR  
3 AUTHORIZATION conducted of a preservice claim prior to an admission or a course of treatment.

4 (27)(28)(a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan  
5 that has a retroactive effect.

6 (b) The term does not include a cancellation or discontinuance under a health plan if the  
7 cancellation or discontinuance of coverage:

8 (i) has only a prospective effect; or

9 (ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a  
10 failure to timely pay required premiums or contributions toward the cost of coverage.

11 (28)(29)(a) "Retrospective review" means a review of medical necessity conducted after services have  
12 been provided to a covered person.

13 (b) The term does not include the review of a claim that is limited to an evaluation of  
14 reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

15 (29)(30)"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a  
16 health care provider other than the one originally making a recommendation for a proposed health care service  
17 to assess the clinical necessity and appropriateness of the initial proposed health care service.

18 (30)(31)"Stabilize" means, with respect to an emergency condition, to ensure that no material  
19 deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the  
20 transfer of the individual from a facility.

21 (31)(32)(a) "Urgent care request" means a request for a health care service or course of treatment with  
22 respect to which the time periods for making a nonurgent care request determination could:

23 (i) seriously jeopardize the life or health of the covered person or the ability of the covered person  
24 to regain maximum function; or

25 (ii) subject the covered person, in the opinion of a health care provider with knowledge of the  
26 covered person's medical condition, to severe pain that cannot be adequately managed without the health care  
27 service or treatment that is the subject of the request.

28 (b) Except as provided in subsection (31)(e) (32)(c), in determining whether a request is to be

1     treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the  
2     judgment of a prudent lay person who possesses an average knowledge of health and medicine.

3           (c)     Any request that a health care provider with knowledge of the covered person's medical  
4     condition determines is an urgent care request within the meaning of subsection (31)(a)-(32)(a) must be treated  
5     as an urgent care request.

6           (32)(33)"Utilization review" means a set of formal techniques designed to monitor the use of or to  
7     evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or  
8     settings. Techniques may include ambulatory review, prospective review, second opinions, certification,  
9     concurrent review, case management, discharge planning, or retrospective review.

10           (33)(34)"Utilization review organization" means an entity that conducts utilization review for one or  
11     more of the following:

12           (a)     an employer with employees who are covered under a health benefit plan or health insurance  
13     policy;

14           (b)     a health insurance issuer providing review for its own health plans or for the health plans of  
15     another health insurance issuer;

16           (c)     a preferred provider organization or health maintenance organization; and

17           (d)     any other individual or entity that provides, offers to provide, or administers hospital, outpatient,  
18     medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract."

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20           **Section 2.** Section 33-32-107, MCA, is amended to read:

21           **"33-32-107. Length of prior authorization.** (1) A Except as provided in subsection (2), certification by  
22     a utilization review organization approving health care services is valid for at least 3 12 months from the date  
23     the health care provider receives the certification unless the covered person loses coverage under the  
24     applicable health plan or health insurance coverage.

25           (2) A certification by a utilization review organization approving a health care service for treatment  
26     of a chronic condition is valid for the duration of the condition. The utilization review organization may not  
27     require the covered person to obtain certification again for the same health care service. The utilization review  
28     organization may require documentation that the chronic condition remains present no more frequently than

1     every 12 months."

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3       **Section 3.** Section 33-32-221, MCA, is amended to read:

4       **"33-32-221. Prior authorization requirements.** (1) A health insurance issuer or an entity that a

5       health insurance issuer IT contracts with to perform a prior authorization on the health insurance issuer's ITS

6       behalf may not perform prior authorization on benefits for:

7           (a)       any generic prescription drug that is not listed within any of the schedules of controlled  
8       substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found  
9       in Title 50, chapter 32, after a covered person has been prescribed the covered drug at the same quantity  
10      without interruption for 6 months;

11           (b)       any prescription drug or drugs, generic or brand name, on the grounds of therapeutic  
12      duplication for the same drug if the covered person has already been subject to prior authorization on the  
13      grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the  
14      prescription drug or drugs was approved;

15           (c)       any prescription drug, generic or brand name, solely because the dosage of the medication for  
16      the covered person has been adjusted by the prescriber of the prescription drug, as long as the dosage is  
17      within the dosage approved by the food and drug administration or is consistent with clinical dosing for the  
18      medication; or

19           (d)       any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic;  
20           (e)       controlled substances found at 21 CFR 1308.15 or the schedules of controlled substances  
21       found in Title 50, chapter 32 AND ANY FORMULARY ORAL OR INHALED NONBIOLOGIC GENERIC PRESCRIPTION DRUG  
22       THAT IS NOT LISTED AS A SPECIALTY TIER DRUG BY MEDICARE PART D, OR WITHIN ANY OF THE SCHEDULES OF  
23       CONTROLLED SUBSTANCES FOUND AT 21 CFR 1308.11 THROUGH 21 CFR 1308.15 OR THE SCHEDULES OF  
24       CONTROLLED SUBSTANCES FOUND IN TITLE 50, CHAPTER 32;

25           (f)(E)    any prescription drug, generic or brand name, prescribed for treatment of a substance use  
26      disorder, provided that the prescription does not exceed the U.S. food and drug administration labeled dosages;  
27      or

28           (g)(F)    AT LEAST ONE PRESCRIPTION DRUG OPTION APPROPRIATE FOR CHILDREN AND ONE APPROPRIATE FOR

1      ADULTS, WITHIN EACH ~~any~~ of the following prescription drugs~~DRUG~~ THERAPEUTIC CLASSES, generic or brand name,

2      except as provided in subsection (3):

3            (i)      an inhaled corticosteroid;

4            (ii)     an inhaled short-acting beta-agonist;

5            (iii)    an inhaled combination corticosteroid and beta-agonist;

6            (iv)    a short-acting insulin for diabetes; or

7            (v)     a long-acting insulin for diabetes.

8            (3)    If an individual has multiple prescriptions for any one kind of prescription drug listed under  
9    subsection (1)(g), a health insurance issuer or its utilization review organization may perform a prior  
10   authorization on all but one prescription.

11            (4)(3)    If the health insurance issuer or its utilization review organization makes an adverse  
12   determination for a prescription drug during prior authorization, the health insurance issuer or its utilization  
13   review organization shall provide a written adverse determination notice that includes a list of reasonable  
14   therapeutic alternatives that are covered by the insurer's formulary.

15            (2)(5)(4)    Any adverse determination for a prescription drug made during prior authorization by a  
16   health insurance issuer must be made by a physician whose specialty focuses on the diagnosis and treatment  
17   of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that  
18   does not result in an adverse determination does not require the involvement of a physician on the part of a  
19   health insurance issuer."