

HOUSE BILL 3092  
By Walley

AN ACT to amend Tennessee Code Annotated, Title 56, relative to policies and procedures used in utilization review processes for mental health care and treatment of chemical dependency populations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding Sections 2 through 8 as a new chapter.

SECTION 2. This act shall be known as and may be cited as the "Mental Health and Chemical Dependency Utilization Review Act".

SECTION 3. The general assembly hereby finds and declares that the purposes of this act are to:

(1) Promote appropriate and quality care for those with mental health or chemical dependency problems;

(2) Eliminate administrative barriers to care such as restrictive gatekeeper access to care, unnecessary and burdensome paperwork demands, and arbitrary definitions of medically beneficial or necessary care for mental health and chemical dependency problems;

(3) Safeguard the confidential nature of any and all information shared about a patient with a mental health or chemical dependency problem, recognizing that utilization review processes for mental health and chemical dependency problems are different than those processes utilized to review the care of physical disorders; and

(4) Guard against administrative discrimination of care for those with mental health or chemical dependency problems in the form of excessive administrative or paperwork requirements in the review of care or late payment of claims.

SECTION 4. For the purposes of this act, the following definitions shall apply:

(1) "Health plan" means any hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization, or managed care plan of any sort offered to individuals or groups in this state by an insurer or provider organized group, even if such insurers or providers group do not have their home office in this state, provided that such plans offer mental health and chemical dependency services to individuals or groups as well as other types of basic health services.

(2) "Provider" means any qualified psychologist, psychiatrist, social worker, psychological examiner, professional counselor, marriage and family therapist or other qualified professional licensed under Tennessee Code Annotated, Title 63, as well as a licensed facility, hospital or agency that is qualified to engage in the assessment, prevention, diagnosis or treatment of mental health problems, including, but not limited to, the diagnosis and treatment of nervous and mental disorders and substance abuse disorders.

(3) "Managed care plan" means a health service plan providing for the financing and delivery of health care services, including mental health and substance abuse services, to individuals or groups enrolled in such plans through: (A) contractual arrangements with selected providers to provide mental health and substance abuse

services, (B) organizational arrangements for ongoing quality assurance, utilization review programs, dispute resolution, and other self-regulatory procedures, (C) financial incentives for the persons enrolled in the plan to use the participating providers and procedures provided by the plan, (D) explicit guidelines for the selection of participating providers, and (E) are commonly offered to individuals or groups with discounted fees or capitated, risk-sharing arrangements of the sort commonly known as preferred provider plans, point of service plans, health maintenance organizations, or other similarly structured entities.

(4) "Mental health care" and "substance abuse care" means any service related to the assessment, prevention diagnosis or treatment of nervous and mental disorders and substance abuse disorders, as defined in the most recent editions of professionally recognized texts for the diagnosis of nervous and mental disorders and substance abuse disorders.

(5) "Provider network" refers to any health plan that restricts access, referrals or choice of mental health or substance abuse providers, who have entered into a contractual agreement with the plan under which such providers are obligated to provide treatment and services under the plan to eligible individuals or groups enrolled in these plans.

(6) "In-network providers, facilities or services" refer to those providers, facilities or services provided to individuals or groups in health care plans enrolled under such health plans.

(7) "Out -of-network providers, facilities or services" refer to providers, facilities, or services provided to an individual or groups who are not members of the provider network of such a health plan.

(8) "Utilization review" programs or processes means a system of reviewing clinical necessity, medical necessity, and appropriateness of health plan services by

providers of facilities provided under a health plan or managed care plan using specified guidelines or clinical protocols. Such a system may include pre-admission certification, the application of best practice guidelines, continued stay criteria, concurrent review, discharge planning, pre-authorization or gatekeeping procedures for initiating access to services, outcomes requirements or measures, retrospective review, and other similar review mechanisms; and

(9) "Clinical necessity" or "medical necessity" shall mean services provided by a facility or providers that are required to identify or treat individuals or groups of patients and are: (A) consistent with the symptoms or diagnosis and treatment of the patient's condition, disease, ailment, or injury, and (B) appropriate with regard to standards of good professional practice, and (C) not solely for the convenience of a patient, provider, or facility, and (D) the most appropriate level of service which can safely be provided to the patient. When applied to the care of an inpatient, it further means that services for the patient's clinical or medical symptoms or condition require that the services cannot be safely provided to the patient as an outpatient.

SECTION 5. Nothing in this act shall be construed in any way to replace or eliminate already existing patient protection laws contained in Title 56 including, but not limited to, policies and procedures for independent review and appeals processes, the proper registration of agents or entities engaged in utilization review activities and other similar sections of Title 56. Additionally, utilization review programs for mental health or chemical dependency disorders shall meet and abide by the following additional criteria in their usual and customary operations:

(1) Any health plan, person, or entity conducting utilization review processes must be first properly registered to conduct such activities with the state;

(2) Any, and all, utilization review programs conducted in the state must comply with the most recent requirements by nationally recognized utilization review accrediting bodies, such as URAC;

(3) Any, and all, utilization review programs shall publicly publish and distribute to consumers, providers, and facilities, a description of review standards and procedures for all levels of care, the specific criteria and standard of care used in conducting any utilization review procedures, and the specific interpretation of these guidelines or protocols in clinical decision-making and utilization review processes;

(4) Clinical protocols and criteria for admission, continued stay, changing levels of care, and discharge from care used in utilized review processes shall be objective and based on sound clinical principles and processes. Such clinical protocols and utilization review processes used shall be filed with the state, and these clinical protocols and utilization review criteria shall be reviewed annually to help promote the clinically appropriate use of services, including receiving annual review comments from mental health and substance abuse care providers of various disciplines;

(5) Any person who recommends denial of care, or determines that a service is not clinically appropriate, shall be, both licensed in Tennessee, and of the same professional discipline and specialty area as the provider seeking authorization of care being denied;

(6) For cases involving greater intensity of care, more focused and specific utilization review processes shall be used in determining the appropriateness of care. Inpatient and residential care settings shall undergo more intensive review, while less restrictive care settings, such as outpatient care, shall not be regularly reviewed, provided the frequency of services does not exceed those limits outlined in this subsection. For inpatient, residential, intensive outpatient programs, partial hospitalization programs, wrap-around services, and other programs requiring more than

two (2) clinical services hours per day, precertification of care and more focused utilization review processes for either in-network or out-of-network providers or facilities shall be permitted, provided such processes abide by policies and procedures outlined in this subsection. Prior authorization shall not be required for emergency services of any sort, either for in-network, or out-of-network providers or facilities;

(7) For traditional outpatient services for in-network providers or facilities, there shall be no precertification or registration of care required, no requirement to access care through any sort of gatekeeper, primary care physician, or other entity to obtain authorization for care, nor shall there be any requirements to submit any sort of utilization review treatment plan for these outpatient services, provided these outpatient services do not exceed one (1) hour per month of psychological testing or six (6) hours per month of individual, family, or group psychotherapy appointments in any combination. For outpatient services by out-of-network providers or facilities, the plan may require an initial precertification or registering procedure that is brief, does not discourage care, secures identifying account information, and solely the diagnosis of the patient's clinical condition. Upon obtaining this precertification information, out-of-network outpatient providers or facilities shall then abide by the same parameters aforementioned in this subsection for in-network providers or facilities in terms of frequency of care, if no treatment plan reviews are to occur. No utilization review shall be required for medication management by psychiatrists on an outpatient basis. No precertification of care shall be required by in-network providers or facilities for the initial outpatient evaluation appointment, provided it does not exceed one (1) hour of care.

When the frequency of services rendered on an outpatient basis exceeds the parameters set in this subsection, a more intensive review of care may occur, for either in-network or out-of-network providers or facilities. These more intensive reviews shall be restricted to one eight by eleven (8 x 11) page of patient information disclosing only

that information necessary for a determination of frequency of care, as is consistent with the need for privacy and confidentiality of the mental health or chemical dependency care being received by the patient. Information in these more focused reviews shall be restricted to current diagnoses, symptoms, activities of daily living, and overall global level of functioning at this time.

SECTION 6. The commissioner of commerce and insurance shall appoint, on an annual basis, a committee to review clinical protocols and utilization review processes utilized by health plans and managed care plans in this state. The committee shall be composed of representatives of managed care and health plans, business and industry leaders, consumers, and providers representative of the various professional mental health and substance abuse providers in the state. The committee shall submit an annual report to the commissioner, reviewing the status of care at this time, and provide recommendations as indicated.

SECTION 6. Every insurer, whether in or out of state, issuing group or individual policies of health insurance in Tennessee that covers facility or provider expenses for mental health care or substance abuse care, shall reimburse claims for those expenses promptly, but no later than thirty (30) working days after receipt of the claim by the insurer, unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within thirty (30) working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. If an uncontested claim is not reimbursed by delivery to the claimant's address of record within thirty (30) working days after receipt, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first calendar day after the thirty (30) working-day period. The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

For the purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. For outpatient mental health or substance abuse services, there shall be a ninety (90) day grace period allowed for late filing of claims or claims denied for administrative reasons (such as sessions rendered outside of a specific timeframe or failure to get a treatment plan submitted by a certain time) provided such care when reviewed was found to be clinically or medically necessary.

SECTION 8. Nothing in this act shall apply to the TennCare program.

SECTION 9. This act shall take effect upon becoming a law, the public welfare requiring it.