

Amendment No. 1 to SB1142

Johnson  
Signature of Sponsor

**AMEND Senate Bill No. 1142\***

**House Bill No. 926**

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-6-703, is amended by adding the following as new subdivisions to be appropriately designated:

(\_) "Adverse determination" means a decision by a utilization review agent that the health care services furnished or proposed to be furnished to a subscriber are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated;

(\_) "Authorization" means a determination by a utilization review agent that a health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service;

(\_) "Clinical criteria" means the written policies, written screening procedures, decision rules, decision abstracts, clinical protocols, practice guidelines, and medical protocols used by the utilization review entity to determine the necessity and appropriateness of health care services;

(\_) "Final adverse determination" means an adverse determination has been upheld by a utilization review entity at the completion of the utilization review entity's appeals process;

(\_) "Health care service" means health care procedures, treatments, or services provided by a facility licensed in this state or provided by a doctor of

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medicine, a doctor of osteopathy, or a health care professional licensed in this state;

( ) “Medically necessary health care services” means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider;

( )

(A) “Preauthorization” means the process by which utilization review agents determine the medical necessity or medical appropriateness of otherwise covered health care services prior to the rendering of such health care services including, but not limited to, preadmission review, pretreatment review, utilization, and case management;

(B) “Preauthorization” also includes any health insurer’s or utilization review agent’s requirement that a subscriber or health care

provider notify the health insurer or utilization review agent prior to providing a health care service.

SECTION 2. Tennessee Code Annotated, Section 56-6-705, is amended by deleting subdivision (a)(2) and by substituting instead the following:

(2)

(A) Any restrictions, preauthorizations, adverse determinations, and final adverse determinations that a utilization review agent places on the preauthorization of health care services must be based on the medical necessity or appropriateness of those services and must be based on written clinical criteria.

(B) Utilization review agents must apply written clinical criteria consistently. Written clinical criteria must:

(i) Be based on nationally recognized standards;

(ii) Be developed in accordance with the current standards of national accreditation entities;

(iii) Be evidence-based;

(iv) Be sufficiently flexible to allow deviations from norms when justified on case-by-case bases; and

(v) Be evaluated and updated if necessary at least annually.

(D) A utilization review agent must make available any current preauthorization requirements and restrictions on its online provider portal. These requirements and restrictions must include any written clinical criteria described in detail with documentation and supporting literature that is easily accessible and readily available to contracted providers. The availability of such prospective patient care treatment

guidelines neither infringes upon existing contracts of the utilization review agent with third-party private companies nor discloses proprietary data.

(E) If a utilization review agent intends either to implement a new preauthorization requirement or restriction, or amend an existing requirement or restriction, the utilization review agent must provide contracted health care providers of written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented and must ensure that the new or amended requirement has been updated on the utilization review agent's online provider portal.

SECTION 3. Tennessee Code Annotated, Section 56-6-705(a)(8), is amended by deleting the existing language and substituting the following:

(8) A utilization review entity must ensure that all adverse determinations are made by a physician. The physician must possess a current license to practice medicine in this state, and must be board certified or eligible in a similar specialty. The physician must make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care items and services. All such medical directors must be licensed in Tennessee.

SECTION 4. No provision of this act shall be applied to any TennCare Dental Benefits Management Program.

SECTION 5. This act shall take effect January 1, 2014, the public welfare requiring it.