

**Senate Commerce and Labor Committee 2**

**Amendment No. 4 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" has the same meaning as defined in § 56-61-102;

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

( ) "Final adverse determination" has the same meaning as defined in § 56-61-102;

( ) "Health care service" means health care procedures, treatments, or services provided by a facility licensed in this state or provided by a doctor of medicine, a doctor of osteopathy, or a health care professional licensed in this state;

( ) "Medical necessity" has the same meaning as defined in § 56-61-102;

( ) "Preauthorization" means the process by which the utilization review agent determines the medical necessity 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;

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

(2)

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

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

(i) Be based on:

(a) Nationally recognized standards including, but not limited to, the standards published by the American College of Cardiology, MCG, Hayes, Inc., or ODG; provided, however, when multiple standards addressing the same treatment protocol exist, the payer shall have the right to select the standard upon which the written clinical criteria will be based; or

(b) Standards developed pursuant to § 50-6-124;

(ii) Be developed in accordance with the current standards of national accreditation entities or with standards developed pursuant to § 50-6-124;

(iii) Ensure quality of care and access to needed health care services;

(iv) Be evidence-based; and

(v) Be evaluated and updated at least annually;

(C) A utilization review agent shall make any current preauthorization requirements and restrictions available on its online provider portal. The utilization review agent shall cite to the standards being used and reference the section of the standards relied upon by the utilization review agent. If the utilization review agent is relying upon proprietary references and documentation in developing the clinical criteria, then the utilization review agent shall provide a citation to the proprietary clinical indications being used. Any non-proprietary supporting references and documentation shall be made available to contracted providers if the utilization review agent develops its own clinical criteria; and

(D) If a utilization review agent intends to either implement a new preauthorization requirement or restriction, or amend an existing requirement or restriction, the utilization review agent shall provide contracted health care providers with written notice, or other form of notice under the terms of the contract, of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented and shall ensure that such restriction or requirement has been updated on the utilization review agent's web site;

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

(8) In the event that nationally recognized standards for a specific treatment protocol do not exist to satisfy the requirements of subdivision (a)(2)(B)(i), a utilization review agent shall ensure that all adverse determinations related to the specific treatment protocol are made by a physician or psychologist. The physician or psychologist shall possess a valid license to practice medicine, and shall be board certified or board eligible, or trained in the similar specialty as the health care provider

who typically manages the medical condition or disease, or provides the health care service;

SECTION 4. Tennessee Code Annotated, Section 56-6-705(b), is amended by deleting the subsection in its entirety and substituting instead the following:

(b) With the exception of those standards contained in subdivisions (a)(2), (a)(8), and (a)(10), the commissioner shall exempt from the standards of this section any utilization review agent who has received accreditation by URAC or NCQA. Standards contained in subdivisions (a)(2) and (a)(8) shall not apply to any TennCare dental benefits management program or any state insurance plan set out in title 8, chapter 27.

SECTION 5. This act shall take effect January 15, 2015, the public welfare requiring it.