

SENATE BILL 1142

By Green

AN ACT to amend Tennessee Code Annotated, Title 56,
relative to utilization review.

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

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, drug formularies or lists of covered drugs, 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 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) If no independently developed evidence-based standards exist for a particular health care item, treatment, test, or imaging procedure, the utilization review agent cannot deny coverage of the treatment, items, test, or imaging procedure based solely on the grounds that the item, treatment, test, or imaging procedure does not meet an evidence-based standard.

(C) 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) Reflect community standards of care; ensure quality of care and access to needed health care services;

(iv) Be evidence-based;

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

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

(D) Prior to establishing, or substantially or materially altering written clinical criteria, a utilization review agent must obtain input from actively practicing physicians within the service area where the written clinical criteria are to be employed. Such physicians must represent major areas of specialty and be certified by the boards of the American Board of Medical Specialties. The utilization review agent will seek input from physicians who are not employees of the utilization review agent.

(E) A utilization review agent must make any current preauthorization requirements and restrictions readily accessible on its web site to subscribers,

health care providers, and the general public. This includes the written clinical criteria. Requirements must be described in detail but also in easily understandable language.

(F) 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 web site.

(G) Agents utilizing preauthorization should make statistics available regarding preauthorization approvals and denials on their web site in a readily accessible format. They should include categories for:

- (i) Physician specialty;
- (ii) Medication or diagnostic test/procedure;
- (iii) Indication offered; and
- (iv) Reason for denial.

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 preauthorizations and adverse determinations are made by a physician. The physician must possess a current and valid non-restricted license to practice medicine in this state, and must be board certified or eligible in the same specialty as the health care provider who typically manages the medical condition or disease or provides the health care service. 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. This act shall take effect January 1, 2014, the public welfare requiring it.