

1 SENATE BILL NO. 380  
2 INTRODUCED BY J. SMALL  
3

4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH CARE INSURANCE LAWS;  
5 PROVIDING FOR EXEMPTIONS FOR PRIOR AUTHORIZATION REQUIREMENTS; PROVIDING  
6 EXEMPTIONS; PROVIDING FOR A PROVIDER'S RIGHT TO AN EXTERNAL REVIEW; REVISING  
7 UTILIZATION REVIEW AND GRIEVANCE PROCEDURES; AMENDING SECTION 33-32-309, MCA; AND  
8 PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE."

9  
10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

11  
12 NEW SECTION. Section 1. Prior authorization requirements. (1) A health insurance issuer may  
13 not perform prior authorization on benefits for:

14 (a) ~~generic prescription drugs that are not listed within any of the schedules of controlled~~  
15 ~~substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found~~  
16 ~~in Title 50, chapter 32;~~

17 (b)(A) any GENERIC prescription drug, generic or brand name, that is not listed within any of the  
18 schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of  
19 controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the COVERED  
20 drug AT THE SAME QUANTITY without interruption for 6 months;

21 (c)(B) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic  
22 duplication FOR THE SAME DRUG if the covered person has already been subject to prior authorization on the  
23 grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the  
24 prescription drug or drugs was approved;

25 (d)(C) any prescription drug, generic or brand name, solely because the dosage of the medication for  
26 the covered person has been adjusted by the prescriber of the prescription drug, AS LONG AS THE DOSAGE IS  
27 WITHIN THE DOSAGE APPROVED BY THE FOOD AND DRUG ADMINISTRATION OR IS CONSISTENT WITH CLINICAL DOSING

1 FOR THE MEDICATION; or

2 ~~(e)(D)~~ any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.

3 (2) Any adverse determination for a prescription drug made during prior authorization by a health  
4 insurance issuer must be made by:

5 (a) ~~— a physician who is in the same specialty as the prescriber of the prescription drug subject to~~  
6 ~~prior authorization ; or~~

7 (b) ~~— a physician whose specialty focuses on the diagnosis and treatment of the condition for which~~  
8 ~~the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse~~  
9 ~~determination does not require the involvement of a physician on the part of a health insurance issuer.~~

10 (3) ~~(a) A health insurance issuer may not perform retrospective review on any benefits when:~~

11 (i) ~~— payment has already been furnished to the provider of a health care service unless the health~~  
12 ~~insurance issuer has a credible reason to believe that fraud or other illegal activity may have occurred involving~~  
13 ~~the health care service for which payment has been furnished; or~~

14 (ii) ~~— a health care service has been previously approved and deemed medically necessary during~~  
15 ~~prior authorization or concurrent review, provided that the health insurance issuer may perform retrospective~~  
16 ~~review if the health care service was delivered in a manner that exceeded the scope or duration of what was~~  
17 ~~approved during prior authorization or concurrent review.~~

18 (b) ~~— Retrospectively reviewing approved, paid, or pending claims or authorizations of health care~~  
19 ~~services for the purposes of informing future utilization review activities is not considered a form of retrospective~~  
20 ~~review.~~

21

22 **NEW SECTION. Section 2.—Exemption from prior authorization requirements.** ~~(1) (A) A health~~  
23 ~~insurance issuer that uses a REQUIRED prior authorization process for A COVERED PERSON'S benefits may not~~  
24 ~~require a AN ORDERING HEALTH CARE provider to obtain prior authorization ON BEHALF OF A COVERED PERSON for a~~  
25 ~~particular benefit CATEGORY OF PRIOR AUTHORIZATION if, in the most recent 6-month JANUARY THROUGH~~  
26 ~~SEPTEMBER evaluation period, as described in subsection (2), THE PROVIDER HAS HAD A MINIMUM OF 10 PRIOR~~  
27 ~~AUTHORIZATION REQUESTS IN A PARTICULAR CATEGORY OF PRIOR AUTHORIZATIONS AND the health insurance issuer~~

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1 ~~has approved or would have approved not less than 90% of the prior authorization requests IN THE PRIOR~~  
2 ~~AUTHORIZATION CATEGORY submitted by the provider for the particular COVERED benefit.~~

3 ~~(B) FOR THE PURPOSES OF THIS SECTION, "ORDERING HEALTH CARE PROVIDER" MEANS A HEALTH CARE~~  
4 ~~PROVIDER AS DEFINED IN 33-32-102, EXCEPT FOR A CORPORATION, INSTITUTION, OR HEALTH CARE FACILITY, WHO IS A~~  
5 ~~PARTICIPATING NETWORK PROVIDER WITH THE HEALTH INSURANCE ISSUER AND WHO REQUESTS OR ORDERS THE~~  
6 ~~HEALTH CARE SERVICE THAT IS THE SUBJECT OF A REQUIRED PRIOR AUTHORIZATION PROCESS.~~

7 ~~(2) Except as provided by subsection (3), a health insurance issuer shall evaluate whether a~~  
8 ~~provider qualifies for an exemption from prior authorization requirements under subsection (1) once every 6~~  
9 ~~months.~~

10 ~~(2) TO BE ELIGIBLE TO QUALIFY FOR AN EXEMPTION, THE ORDERING HEALTH CARE PROVIDER SHALL~~  
11 ~~REQUEST THE EXEMPTION IN WRITING.~~

12 ~~(3) A health insurance issuer may continue an exemption under subsection (1) without evaluating~~  
13 ~~whether the provider qualifies for the exemption under subsection (1) for a particular evaluation period.~~

14 ~~(4) A provider is not required to request an exemption under subsection (1) to qualify for the~~  
15 ~~exemption.~~

16 ~~(3) IF AN ORDERING HEALTH CARE PROVIDER QUALIFIES FOR THE EXEMPTION, THE HEALTH INSURANCE~~  
17 ~~ISSUER SHALL PROVIDE A NOTICE TO THE PROVIDER THAT INCLUDES:~~

18 ~~(A) A STATEMENT THAT THE PROVIDER QUALIFIES FOR AN EXEMPTION FROM PRIOR AUTHORIZATION~~  
19 ~~REQUIREMENTS UNDER SUBSECTION (1);~~

20 ~~(B) A LIST OF THE COVERED BENEFITS OR HEALTH CARE SERVICES TO WHICH THE EXEMPTION APPLIES;~~

21 ~~AND~~

22 ~~(C) A STATEMENT OF THE DURATION OF THE EXEMPTION.~~

23 ~~(4) A HEALTH INSURANCE ISSUER MAY DENY A REQUEST FOR EXEMPTION FROM PRIOR AUTHORIZATION~~  
24 ~~REQUIREMENTS UNDER SUBSECTION (1) IF THE HEALTH INSURANCE ISSUER PROVIDES THE ORDERING HEALTH CARE~~  
25 ~~PROVIDER WITH ACTUAL STATISTICS AND DATA FOR THE RELEVANT PRIOR AUTHORIZATION REQUEST EVALUATION PERIOD~~  
26 ~~AND DETAILED INFORMATION SUFFICIENT TO DEMONSTRATE THAT THE PROVIDER DOES NOT MEET THE CRITERIA UNDER~~  
27 ~~SUBSECTION (1) FOR AN EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS FOR THE PARTICULAR COVERED~~

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1 ~~BENEFIT OR HEALTH CARE SERVICE;~~

2 ~~(5) — (A) A HEALTH INSURANCE ISSUER MAY ELECT TO EVALUATE DURING AN ANNUAL EVALUATION PERIOD~~

3 ~~WHETHER A HEALTH CARE PROVIDER CONTINUES TO QUALIFY FOR A PREVIOUSLY GRANTED EXEMPTION UNDER~~

4 ~~SUBSECTION (1);~~

5 ~~(B) — A HEALTH INSURANCE ISSUER MAY ELECT TO CONTINUE AN EXEMPTION GRANTED UNDER SUBSECTION~~

6 ~~(1) WITHOUT EVALUATING DURING AN ANNUAL EVALUATION PERIOD WHETHER THE HEALTH CARE PROVIDER CONTINUES~~

7 ~~TO QUALIFY FOR THE EXEMPTION;~~

8 ~~(C) — A HEALTH INSURANCE ISSUER SHALL PROVIDE NOTICE TO A HEALTH CARE PROVIDER, CONSISTENT~~

9 ~~WITH THE NOTICE REQUIREMENTS OF SUBSECTION (3), OF A DETERMINATION MADE UNDER EITHER SUBSECTION (5)(A)~~

10 ~~OR SUBSECTION (5)(B);~~

11 ~~(6) — (A) A HEALTH INSURANCE ISSUER MAY TERMINATE A PREVIOUSLY GRANTED EXEMPTION:~~

12 ~~(I) — BY ISSUING THE HEALTH CARE PROVIDER NOTICE OF INTENT TO TERMINATE AN EXEMPTION FROM PRIOR~~

13 ~~AUTHORIZATION REQUIREMENTS AT ANY TIME DURING OCTOBER THROUGH NOVEMBER OF EACH YEAR, TO BE EFFECTIVE~~

14 ~~JANUARY 1 OF THE FOLLOWING CALENDAR YEAR;~~

15 ~~(II) — IF, ON THE BASIS OF AN EXAMINATION OF A RANDOM SAMPLE OF CLAIMS THAT REPRESENT NOT FEWER~~

16 ~~THAN 10 AND NOT MORE THAN 50 HEALTH CARE SERVICES SUBJECT TO A PARTICULAR CATEGORY OF PRIOR~~

17 ~~AUTHORIZATION SUBMITTED BY THE HEALTH CARE PROVIDER DURING THE MOST RECENT EVALUATION PERIOD~~

18 ~~DESCRIBED BY SUBSECTION (1), THE HEALTH INSURANCE ISSUER MAKES A DETERMINATION THAT LESS THAN 90% OF~~

19 ~~THE SERVICES SUBJECT TO A PARTICULAR CATEGORY OF PRIOR AUTHORIZATION MET THE MEDICAL NECESSITY CRITERIA~~

20 ~~THAT WOULD HAVE BEEN USED BY THE HEALTH INSURANCE ISSUER WHEN CONDUCTING PRIOR AUTHORIZATION REVIEW~~

21 ~~FOR THE PARTICULAR COVERED BENEFIT DURING THE RELEVANT EVALUATION PERIOD; AND~~

22 ~~(III) — THE HEALTH INSURANCE ISSUER PROVIDES THE HEALTH CARE PROVIDER WITH:~~

23 ~~(A) — THE SAMPLE INFORMATION USED TO MAKE THE DETERMINATION UNDER SUBSECTION (6)(A)(II); AND~~

24 ~~(B) — A PLAIN LANGUAGE EXPLANATION OF HOW THE PROVIDER MAY APPEAL THE DETERMINATION UTILIZING~~

25 ~~THE HEALTH INSURANCE ISSUER'S PROVIDER DISPUTE RESOLUTION PROCESS;~~

26 ~~(B) — IF A PRIOR AUTHORIZATION EXEMPTION IS TERMINATED BY A HEALTH INSURANCE ISSUER DUE TO~~

27 ~~FRAUD, WASTE, ABUSE, OR CRIMINAL CONDUCT, THE TERMINATION MUST TAKE EFFECT IMMEDIATELY;~~

1           ~~(7) — IF A HEALTH INSURANCE ISSUER DOES NOT FINALIZE THE TERMINATION AS SPECIFIED IN SUBSECTION~~  
2 ~~(6), THEN THE HEALTH CARE PROVIDER IS CONSIDERED TO CONTINUE TO QUALIFY FOR THE EXEMPTION;~~  
3           ~~(5)(8) — (A) A IF A HEALTH CARE PROVIDER IS TERMINATED PURSUANT TO SUBSECTION (6), THE provider's~~  
4 ~~exemption from prior authorization requirements under subsection (1) remains in effect until:~~  
5           ~~(a) — the 30th day after the date the health insurance issuer notifies the provider of the issuer's~~  
6 ~~determination to rescind the exemption under subsection (1), if the provider does not appeal the issuer's~~  
7 ~~determination; or JANUARY 1 OF THE FOLLOWING CALENDAR YEAR;~~  
8           ~~(b) — if IF the HEALTH CARE provider appeals the determination, the PROVIDER'S EXEMPTION REMAINS IN~~  
9 ~~EFFECT UNTIL THE fifth 5TH day after the date an independent review organization THE FINAL REVIEWER IN THE~~  
10 ~~HEALTH INSURANCE ISSUER'S DISPUTE RESOLUTION PROCESS, AS SET FORTH IN SUBSECTION (10), affirms the HEALTH~~  
11 ~~INSURANCE issuer's determination to rescind TERMINATE the exemption., PROVIDED, HOWEVER, THAT IF THE~~  
12 ~~TERMINATION IS AFFIRMED BY THE HEALTH INSURANCE ISSUER, THE EFFECTIVE DATE OF THE TERMINATION REMAINS~~  
13 ~~JANUARY 1 AND THE ISSUER MAY, IN ITS DISCRETION, REVIEW ANY CLAIMS FOR MEDICAL NECESSITY AFTER THE~~  
14 ~~EFFECTIVE DATE OF THE TERMINATION;~~  
15           ~~(6) — If a health insurance issuer does not finalize a rescission determination as specified in~~  
16 ~~subsection (5), then the provider is considered to have met the criteria under subsection (1) to continue to~~  
17 ~~qualify for the exemption.~~  
18           ~~(7) — A health insurance issuer may rescind an exemption from prior authorization requirements~~  
19 ~~under subsection (1) only:~~  
20           ~~(a) — during January or June of each year;~~  
21           ~~(b) — if the health insurance issuer makes a determination, on the basis of an examination of a~~  
22 ~~random sample of not fewer than 20 and no more than 50 claims submitted by the provider during the most~~  
23 ~~recent evaluation period described by subsection (2), that less than 90% of the claims for the particular benefit~~  
24 ~~met the medical necessity criteria that would have been used by the health insurance issuer when conducting~~  
25 ~~prior authorization review for the particular benefit during the relevant evaluation period; and~~  
26           ~~(c) — if the health insurance issuer complies with other applicable requirements specified in this~~  
27 ~~section, including:~~

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- 1           ~~(i) — notifying the provider not less than 25 days before the proposed rescission is to take effect;~~
- 2    ~~and~~
- 3           ~~(ii) — providing with the notice under subsection (7)(c) (i):~~
- 4           ~~(A) — the sample information used to make the determination under subsection (7) (b); and~~
- 5           ~~(B) — a plain language explanation of how the provider may appeal and seek an independent review~~
- 6    ~~of the determination.~~
- 7           ~~(8)(9) — A determination made under subsection (7)(b) (6) must be made by A LICENSED HEALTH CARE~~
- 8    ~~PROVIDER, an individual licensed to practice medicine under Title 37, chapter 3. For a determination made under~~
- 9    ~~subsection (7)(b) with respect to a physician, the determination must be made by an individual licensed to~~
- 10   ~~practice medicine under Title 37, chapter 3, who has the same or similar specialty as that physician.~~
- 11          ~~(9) — A health insurance issuer may deny an exemption from prior authorization requirements under~~
- 12   ~~subsection (1) only if:~~
- 13          ~~(a) — the provider does not have the exemption at the time of the relevant evaluation period; and~~
- 14          ~~(b) — the health insurance issuer provides the provider with actual statistics and data for the relevant~~
- 15   ~~prior authorization request evaluation period and detailed information sufficient to demonstrate that the provider~~
- 16   ~~does not meet the criteria for an exemption from prior authorization requirements for the particular benefit under~~
- 17   ~~subsection (1).~~
- 18          ~~(10) — A HEALTH CARE PROVIDER WHO IS DENIED A PRIOR AUTHORIZATION EXEMPTION OR WHOSE EXISTING~~
- 19   ~~PRIOR AUTHORIZATION IS TO BE TERMINATED MAY REQUEST AN APPEAL AND REVIEW OF THAT DETERMINATION BY~~
- 20   ~~UTILIZING THE HEALTH INSURANCE ISSUER'S PROVIDER DISPUTE RESOLUTION PROCESS.~~
- 21          ~~(10) — A health insurance issuer may not deny or reduce payment to a provider for a benefit for which~~
- 22   ~~the provider has qualified for an exemption from prior authorization requirements under subsection (1) based on~~
- 23   ~~medical necessity or appropriateness of care unless the provider:~~
- 24          ~~(a) — knowingly and materially misrepresented the benefit in a request for payment submitted to the~~
- 25   ~~health insurance issuer with the specific intent to deceive and obtain an unlawful payment from the issuer; or~~
- 26          ~~(b) — failed to substantially furnish or deliver the benefit.~~
- 27          ~~(11) — A health insurance issuer may not conduct a retrospective review of a benefit subject to an~~

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1 ~~exemption except:~~

2 ~~(a) — to determine if the provider still qualifies for an exemption under this section; or~~

3 ~~(b) — if the health insurance issuer has a reasonable cause to suspect a basis for denial exists under~~

4 ~~subsection (10).~~

5 ~~(12) — Not later than 5 days after qualifying for an exemption from prior authorization requirements~~

6 ~~under subsection (1), a health insurance issuer must provide to a provider a notice that includes:~~

7 ~~(a) — a statement that the provider qualifies for an exemption from prior authorization requirements~~

8 ~~under subsection (1);~~

9 ~~(b) — a list of the benefits to which the exemption applies; and~~

10 ~~(c) — a statement of the duration of the exemption.~~

11 ~~(13) — If a provider submits a prior authorization request for a benefit for which the provider qualifies~~

12 ~~for an exemption from prior authorization requirements under subsection (1), the health insurance issuer shall~~

13 ~~promptly provide a notice to the provider that includes:~~

14 ~~(a) — the information described by subsection (12); and~~

15 ~~(b) — a notification of the health insurance issuer's payment requirements.~~

16 ~~(14)(11) Nothing in this section may be construed to:~~

17 ~~(a) — authorize a HEALTH CARE provider to provide a health care service outside the scope of the~~

18 ~~provider's applicable license issued under Title 37; or~~

19 ~~(b) — require a health insurance issuer to pay for a COVERED benefit that is NOT A MEDICALLY~~

20 ~~NECESSARY COVERED BENEFIT OR THAT IS performed in violation of the laws of this state.~~

21

22 **NEW SECTION. Section 3. — Provider right to external review.** (1) Notwithstanding any other

23 provision of this part, a provider has the right to an independent external review of an adverse determination

24 regarding a prior authorization exemption under Title 33, chapter 32, part 2, conducted by an independent

25 review organization. A health insurance issuer may not require a provider to engage in an internal grievance

26 process before requesting a review by an independent review organization under this part.

27 (2) — A health insurance issuer shall pay:

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1 as provided in 33-32-211(9).

2 (10) — (a) A health insurance issuer may provide the notice required under this section orally, in  
3 writing, or electronically.

4 (b) — If notice of the adverse determination is provided orally, the health insurance issuer shall  
5 provide written or electronic notice of the adverse determination within 3 days after the oral notification.

6 (11) — (a) Notwithstanding any other provision of this part, any adverse determination for a  
7 prescription drug made during the course of prior authorization is eligible for an expedited review of a  
8 grievance, initiated by the prescriber of the prescription drug, if the prescriber of the prescription drug subject to  
9 prior authorization believes that, in the prescriber's professional judgment, the covered person will suffer  
10 serious harm without access to the prescription drug subject to prior authorization.

11 (b) — On initiation of the expedited review of the grievance by the prescriber of the prescription drug  
12 subject to prior authorization, a health insurance issuer shall render a decision on the expedited review of the  
13 grievance within 48 hours and provide written notice.

14 (c) — If a health insurance issuer does not render a decision on the expedited review of the  
15 grievance initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of  
16 initiation, the initial adverse determination must be automatically overturned, and the covered person must be  
17 granted immediate approval for coverage of the prescription drug subject to prior authorization.

18 (d) — The decision rendered during the expedited review of the grievance by a health insurance  
19 issuer must be made by a physician who is in the same specialty as the prescriber of the prescription drug  
20 subject to prior authorization or must be made by a physician whose specialty focuses on the diagnosis and  
21 treatment of the condition for which the prescription drug was prescribed to treat. "

22  
23 **NEW SECTION. Section 2. Codification instruction.** (1) ~~[Sections 1 and 2] are~~ [Section 1] is  
24 intended to be codified as an integral part of Title 33, chapter 32, part 2, and the provisions of Title 33, chapter  
25 32, part 2, apply to ~~[sections 1 and 2]~~ [section 1].

26 (2) — ~~[Section 3] is intended to be codified as an integral part of Title 33, chapter 32, part 4, and the~~  
27 ~~provisions of Title 33, chapter 32, part 4, apply to [section 3].~~