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SENATE BILL 156

45TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2001

INTRODUCED BY

Dede Feldman

FOR THE LEGISLATIVE HEALTH SUBCOMMITTEE

AN ACT

RELATING TO HEALTH; PROVIDING CRITERIA FOR THE DETERMINATION OF THE MEDICAL NECESSITY OF HEALTH CARE SERVICES; ENACTING SECTIONS OF THE NMSA 1978.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. A new Section 24-22-1 NMSA 1978 is enacted to read:

"24-22-1. [NEW MATERIAL] SHORT TITLE. -- Chapter 24, Article 22 NMSA 1978 may be cited as the "Medical Necessity Act". "

Section 2. A new Section 24-22-2 NMSA 1978 is enacted to read:

"24-22-2. [NEW MATERIAL] DEFINITIONS. -- As used in the Medical Necessity Act:

A. "covered benefits" means those health care services provided under a policy, contract, certificate or

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1 agreement or in accordance with state or federal law by a
2 health care insurer, plan administrator or state health
3 program;

4 B. "health care insurer" means a person that has a
5 valid certificate of authority under the New Mexico Insurance
6 Code to act as an insurer, fraternal benefit society, health
7 maintenance organization, nonprofit health care plan, prepaid
8 dental plan or other entity engaged in the administration or
9 reimbursement of covered benefits;

10 C. "health care professional" means a physician or
11 other health care practitioner, including a pharmacist, who is
12 licensed, certified or otherwise authorized by the state to
13 provide health care services consistent with state law;

14 D. "health care provider" means a person that is
15 licensed or otherwise authorized by the state to furnish
16 health care services and includes health care professionals
17 and health care facilities;

18 E. "health care services" means services or
19 supplies provided by a health care provider for the
20 prevention, diagnosis, treatment, cure or relief of a health
21 condition, illness, injury, disability or disease, including
22 physical, mental and behavioral health;

23 F. "medical necessity" means that health care
24 services are:

25 (1) appropriate to prevent, diagnose,

1 palliate, ameliorate or treat a health condition, illness,
2 injury, disability or disease and to enable a person to
3 attain, maintain, regain or retard deterioration of functional
4 capacity without which the person's health may be adversely
5 limited or affected;

6 (2) delivered in the amount, duration, scope
7 and setting appropriate to the physical, mental and behavioral
8 health needs and circumstances of the person;

9 (3) based on standards of care; and

10 (4) not primarily for the convenience of the
11 person, health care provider or payer;

12 G. "medical or utilization review" means the
13 review and evaluation of the medical necessity,
14 appropriateness, efficacy and efficiency of health care
15 services provided or proposed to be provided by a health care
16 provider to a person;

17 H. "plan administrator" means a person acting on
18 behalf of a health care insurer or other entity engaged in the
19 administration, reimbursement or medical or utilization review
20 of covered benefits;

21 I. "risk-bearing entity" means a person that
22 assumes financial responsibility for the provision of covered
23 benefits by accepting prepayment for some or all of the cost
24 of the health care services;

25 J. "standard of care" means protocol, criteria,

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1 parameters or guidelines, based on professional knowledge or
2 available research evidence, for:

3 (1) the diagnosis or treatment of a health
4 condition, illness, injury or disease;

5 (2) the maintenance of health; or

6 (3) the maintenance or attainment of
7 functional capacity; and

8 K. "state health program" means a program
9 operated or funded, in whole or in part, by the state to
10 provide covered benefits pursuant to state or federal law,
11 including employment-sponsored, entitlement, categorical or
12 specialized health care service programs. "

13 Section 3. A new Section 24-22-3 NMSA 1978 is enacted to
14 read:

15 "24-22-3. [NEW MATERIAL] DETERMINATION OF MEDICAL
16 NECESSITY. --

17 A. All determinations of medical necessity shall:

18 (1) be based on a person's physical, mental
19 and behavioral health information provided by a health care
20 professional who has personally evaluated the person;

21 (2) take into consideration any views or
22 choices expressed by the person or his legal guardian, agent
23 or surrogate decision-maker regarding proposed health care
24 services;

25 (3) take into consideration unique

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1 circumstances, including diverse cultural and linguistic
2 situations, that may affect the appropriateness of a
3 particular health care service for the person; and

4 (4) be based on standards of care.

5 B. Decisions to deny, modify, reduce, limit or
6 terminate health care services on the grounds of medical
7 necessity shall be:

8 (1) made in accordance with the provisions of
9 the Medical Necessity Act; and

10 (2) based on the review, assessment and
11 recommendation of a health care professional, acting within
12 the scope of his license, who is an expert and would generally
13 provide the type of health care service that is the subject of
14 the determination.

15 C. Decisions regarding medical necessity, if made
16 on a concurrent or prospective basis, shall be made on a
17 timely basis as required by the exigencies of the situation
18 and shall be made within twenty-four hours whenever:

19 (1) the life or health of the person may be
20 jeopardized;

21 (2) the person's ability to regain maximum
22 function may be jeopardized;

23 (3) the health care provider reasonably
24 requests an expedited decision; or

25 (4) the medical exigencies of the case

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1 require an expedited or immediate decision.

2 D. Except as provided for in Subsection C of this
3 section, all other decisions, and notification of those
4 decisions, shall be made within five days, which may be
5 extended to a maximum of ten days if:

6 (1) the cause for the delay is beyond
7 reasonable control;

8 (2) the delay will not result in increased
9 medical risk to the person; and

10 (3) a written explanation is provided to the
11 requesting health care provider and the person within the
12 original five-day review period.

13 E. Notification of a medical necessity
14 determination shall be made by the plan administrator or state
15 health program to the health care provider or the person
16 within the respective time requirement specified in Subsection
17 C of this section. The notification shall include a clear and
18 complete explanation of the medical necessity determination
19 and of the available appeal or review rights, including the
20 process and time frames necessary for exercising them.

21 F. Determination of medical necessity does not
22 mean that the health care service is a covered benefit."

23 Section 4. A new Section 24-22-4 NMSA 1978 is enacted to
24 read:

25 "24-22-4. [NEW MATERIAL] STANDARDS OF CARE. --

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1 A. Standards of care used in determinations of
2 medical necessity shall be:

3 (1) consistent with nationally recognized,
4 adopted or approved standards of care, including those
5 developed by the federal government or national professional
6 associations, groups or boards;

7 (2) to the extent nationally recognized
8 standards of care are not available, based on objective
9 information and research and consistent with generally
10 accepted practices of health care providers who are experts in
11 the area that is the subject of the standard of care;

12 (3) approved by and conducted under the
13 conditions required by an institutional research entity
14 established in accordance with federal law; or

15 (4) to the extent reasonably feasible,
16 evidence-based.

17 B. All standards of care used in the determination
18 of medical necessity shall be made available, upon request, to
19 the person or the legal guardian, agent or surrogate decision-
20 maker of the person who is the subject of the medical
21 necessity determination and to the health care professional. "

22 Section 5. A new Section 24-22-5 NMSA 1978 is enacted to
23 read:

24 "24-22-5. [NEW MATERIAL] INCENTIVES. -- No person
25 responsible for medical necessity determinations may offer

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1 direct or indirect incentives, financial or otherwise, to
2 those who conduct medical or utilization reviews to make
3 determinations of medical necessity that provide less than
4 medically necessary and appropriate health care services or
5 that may adversely affect the health and well-being of a
6 person. "

7 Section 6. A new Section 24-22-6 NMSA 1978 is enacted to
8 read:

9 "24-22-6. [NEW MATERIAL] APPLICABILITY. --The provisions
10 of the Medical Necessity Act shall apply to all persons making
11 retrospective, concurrent or prospective medical or
12 utilization review decisions regarding medical necessity,
13 except to health care providers making decisions while
14 directly providing services to a person. These decision-
15 makers include:

- 16 A. health care insurers;
- 17 B. plan administrators;
- 18 C. risk-bearing entities to the extent decisions
19 are made regarding medical necessity;
- 20 D. persons acting on behalf of Title 19 and Title
21 21 programs of the federal Social Security Act to the extent
22 not specifically prohibited by federal law; and
- 23 E. other state health programs or persons acting
24 on behalf of those programs. "