SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 156

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

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:

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A. "covered benefits" means those health care services provided or health care provider authorized under a policy, contract, certificate or agreement or in accordance with state or federal law by a health care insurer, plan administrator or state health program;

B. "health care insurer" means a person that has a valid certificate of authority under the New Mexico Insurance Code to act as an insurer, fraternal benefit society, health maintenance organization, nonprofit health care plan, prepaid dental plan or other entity engaged in the administration or reimbursement of covered benefits but does not include casualty insurance;

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

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

E. "health care services" means services or supplies provided by a health care provider for the prevention, diagnosis, treatment, cure or relief of a health condition, illness, injury, disability or disease, including physical,

mental and behavioral health;

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

(1) appropriate to prevent, diagnose, palliate, ameliorate, rehabilitate or treat a health condition, illness, injury, disability or disease and to enable a person to attain, maintain, regain or retard deterioration of functional capacity without which the person's health may be adversely limited or affected;

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

(3) based on standards of care; and

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

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

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

I. "risk-bearing entity" means a person that

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assumes financial responsibility for the provision of covered benefits by accepting prepayment for some or all of the cost of the health care services;

J. "standard of care" means protocol, criteria, parameters or guidelines, based on professional knowledge or available research evidence, for:

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

(2) the maintenance of health; or

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

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

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

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

A. An individual making a medical or utilization review determination shall base his determination on standards of care and, to the extent made known to the individual making the determination, on a person's physical, mental and

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behavioral health information provided by a health care professional who has personally evaluated the person.

B. An individual making a medical or utilization review determination, to the extent made known to him by a heath care professional who has personally evaluated the person, shall take into consideration:

(1) views or choices expressed by the person or his legal guardian, agent or surrogate decision-maker regarding proposed health care services; and

(2) unique circumstances, including diverse cultural and linguistic situations, that may affect the appropriateness of a particular health care service for the person.

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

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

(2) based on the review, assessment and recommendation of a health care professional, acting within the scope of his license, who is an expert or has knowledge about or would generally provide the type of health care service that is the subject of the determination; and

(3) made in writing or, if required by the

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exigencies of the situation, by telephone.

D. Medical or utilization review determinations, if made on a concurrent or prospective basis, shall be made on a timely basis as required by the exigencies of the situation.

E. Notification of a medical or utilization review determination shall be made by the plan administrator or state health program to the health care provider or the person. The notification shall include a clear and complete explanation of the medical or utilization review determination and of the available appeal or review rights, including the process and time frames necessary for exercising them.

F. Determination of medical necessity does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit."

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

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

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

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

(2) to the extent nationally recognized

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standards of care are not available, based on objective information and research and consistent with generally accepted practices of health care providers who are experts in the area that is the subject of the standard of care;

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

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

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

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

"24-22-5. [NEW MATERIAL] INCENTIVES.--No person responsible for medical necessity determinations may offer direct or indirect incentives, financial or otherwise, to those who conduct medical or utilization reviews to make determinations of medical necessity that provide less than medically necessary and appropriate health care services or that may adversely affect the health and well-being of a person."

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

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

A. health care insurers;

B. plan administrators;

C. risk-bearing entities to the extent decisions are made regarding medical necessity;

D. persons acting on behalf of Title 19 and Title 21 programs of the federal Social Security Act to the extent not specifically prohibited by federal law; and

E. other state health programs or persons acting on behalf of those programs."

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