AN ACT GENERALLY REVISING UTILIZATION REVIEW LAWS; ESTABLISHING REQUIREMENTS FOR INDIVIDUALS MAKING OR REVIEWING ADVERSE DETERMINATIONS; PROVIDING FOR QUALIFICATIONS OF INDIVIDUALS MAKING OR REVIEWING ADVERSE DETERMINATIONS; REVISING A DEFINITION; AMENDING SECTIONS 33-32-102 AND 33-32-107, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.

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

Section 1. Exemption for continuity of care on change in health plans. (1) When a covered person changes health plans, a health insurance issuer or its utilization review organization shall honor a certification for health care services granted by a previous health insurance issuer or its utilization review organization for at least the first 3 months of the person's coverage under a new health plan on receiving information documenting the certification from the covered person or the person's health care provider, provided that the services are covered services under the new plan.

(2) During the time period specified in subsection (1), a utilization review organization may perform its own review to grant certification.

(3) If a change in coverage or approval criteria occurs for a previously certified health care service, the change in coverage or approval criteria does not affect a covered person who received certification for a health care service before the effective date of the change for the remainder of the authorization period or the covered person's plan year, whichever is shorter.

(4) A utilization review organization shall continue to honor a certification for health care services it has granted to a covered person when the person changes to a product offered by the same health insurance issuer, provided that the services are covered under the new plan.

Section 2. Qualifications of individuals making or reviewing adverse determinations. (1) A health insurance issuer or its utilization review organization shall ensure that all adverse determinations pursuant to 33-32-211 or 33-32-212 are made by:

(a) a physician when the request is by or on behalf of a physician; or

(b) a health care professional licensed in the same profession as the health care professional making the request, or, in any case, by a physician.

(2) A physician or other health care professional making an adverse determination pursuant to subsection (1) must:

(a) possess a current and valid nonrestricted license; and

(b) have experience treating and managing patients with the medical condition or disease for which the health care service is being requested, or shall refer the review to a physician with the requisite specialized knowledge and experience.

(3) A health insurance issuer or its utilization review organization shall ensure that only a physician reviews a grievance as provided under 33-32-308 or 33-32-309. A physician making an adverse determination or reviewing a grievance must:

(a) possess a current and valid nonrestricted license to practice medicine; and

(b) be of a specialty that focuses on the diagnosis and treatment of the condition that is being treated.

(4) A health insurance issuer or its utilization review organization must make all adverse determinations under the clinical direction of one of the utilization review organization's medical directors who is responsible for the oversight of the utilization review activities for covered persons in the state. A medical director used for this purpose must be a licensed physician.

(5) For the purposes of this section, "adverse determination" has the same meaning as provided in 33-32-102(1)(a) or (1)(c).

Section 3. Section 33-32-102, MCA, is amended to read:

"**33-32-102. Definitions.** As used in this chapter, the following definitions apply:

(1) "Adverse determination", except as provided in 33-32-402, means:

(a) a determination by a health insurance issuer or its designated utilization review organization that, based on the provided information and after application of any utilization review technique, a requested benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not made in whole or in part for the requested benefit because the requested benefit does not meet the health insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness or is determined to be experimental or investigational;

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a person's eligibility to participate in the health insurance issuer's health plan;

(c) any prospective review or retrospective review of a benefit determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit; or

(d) a rescission of coverage determination.

(2) "Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means:

(a) a person to whom a covered person has given express written consent to represent the covered person;

(b) a person authorized by law to provided substituted consent for a covered person; or

(c) a family member of the covered person, or the covered person's treating health care provider, only if the covered person is unable to provide consent.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or otherwise complex health conditions.

(5) "Certification" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and level of effectiveness.

(6) "Chronic condition" means a condition that lasts 1 year or more and requires ongoing medical attention or limits activities of daily living.

~~(6)~~(7) "Clinical peer" means a physician or other health care provider who:

(a) holds a nonrestricted license in a state of the United States; and

(b) is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

~~(7)~~(8) "Clinical review criteria" means the written policies, written screening procedures, decision abstracts, determination rules, clinical and medical protocols, practice guidelines, or any other criteria or rationale used by a health insurance issuer or its designated utilization review organization to determine the medical necessity of health care services.

~~(8)~~(9) "Concurrent review" means a utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or another inpatient or outpatient health care setting.

~~(9)~~(10) "Cost sharing" means the share of costs that a covered member pays under the health insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

~~(10)~~(11)"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health plan.

~~(11)~~(12)"Covered person" means a policyholder, a certificate holder, a member, a subscriber, an enrollee, or another individual participating in a health plan.

~~(12)~~(13)"Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

~~(13)~~(14)"Emergency medical condition" has the meaning provided in 33-36-103.

~~(14)~~(15)"Emergency services" has the meaning provided in 33-36-103.

~~(15)~~(16)"External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.

~~(16)~~(17)"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer or its designated utilization review organization at the completion of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.

~~(17)~~(18)"Grievance" means a written complaint or an oral complaint if the complaint involves an urgent

care request submitted by or on behalf of a covered person regarding:

(a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for health care services; or

(c) matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

~~(18)~~(19)"Health care provider" or "provider" means a person, corporation, facility, or institution licensed by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:

(a) a physician, physician assistant, advanced practice registered nurse, health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed professional counselor; and

(b) an officer, employee, or agent of a person described in subsection ~~(18)(a)~~ (19)(a) acting in the course and scope of employment.

~~(19)~~(20)"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or durable medical equipment.

~~(20)~~(21)"Health insurance issuer" has the meaning provided in 33-22-140.

~~(21)~~(22)"Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are:

(a) in accordance with generally accepted standards of practice;

(b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

(c) not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

~~(22)~~(23)"Network" means the group of participating providers providing services to a managed care

plan.

~~(23)~~(24)"Participating provider" means a health care provider who, under a contract with a health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

~~(24)~~(25)"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in this subsection.

~~(25)~~(26)"Preservice claim" means a request for benefits or payment from a health insurance issuer for health care services that, under the terms of the health insurance issuer's contract of coverage, requires authorization from the health insurance issuer or from the health insurance issuer's designated utilization review organization prior to receiving the services.

~~(26)~~(27)"Prospective review" means a utilization review, medical necessity review, or prior authorization conducted of a preservice claim prior to an admission or a course of treatment.

~~(27)~~(28)(a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance under a health plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

~~(28)~~(29)(a) "Retrospective review" means a review of medical necessity conducted after services have been provided to a covered person.

(b) The term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

~~(29)~~(30)"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a health care provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

~~(30)~~(31)"Stabilize" means, with respect to an emergency condition, to ensure that no material deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the transfer of the individual from a facility.

~~(31)~~(32)(a) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination could:

(i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) subject the covered person, in the opinion of a health care provider with knowledge of the covered person's medical condition, to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b) Except as provided in subsection ~~(31)(c)~~ (32)(c), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a health care provider with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subsection ~~(31)(a)~~ (32)(a) must be treated as an urgent care request.

~~(32)~~(33)"Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

~~(33)~~(34)"Utilization review organization" means an entity that conducts utilization review for one or more of the following:

(a) an employer with employees who are covered under a health benefit plan or health insurance policy;

(b) a health insurance issuer providing review for its own health plans or for the health plans of another health insurance issuer;

(c) a preferred provider organization or health maintenance organization; and

(d) any other individual or entity that provides, offers to provide, or administers hospital, outpatient,

medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract."

Section 4. Section 33-32-107, MCA, is amended to read:

"**33-32-107. Length of prior authorization.** (1) A certification by a utilization review organization approving health care services is valid for at least ~~3~~ 6 months from the date the health care provider receives the certification unless the covered person loses coverage under the applicable health plan or health insurance coverage or unless a shorter duration is warranted by the United States food and drug administration guidance or other patient safety concerns.

(2) A certification by a utilization review organization approving a health care service for treatment of a chronic condition is valid for 12 months, unless a shorter duration is warranted by the United States food and drug administration's guidance or other patient safety concerns."

Section 5. Codification instruction. [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 32, and the provisions of Title 33, chapter 32, apply to [sections 1 and 2].

Section 6. Effective date. [This act] is effective January 1, 2026.

- END -

I hereby certify that the within bill,

HB 398, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2025.

_____

President of the Senate

Signed this _____day

of_____, 2025.

HOUSE BILL NO. 398

INTRODUCED BY J. KARLEN, V. RICCI, E. BUTTREY, J. ETCHART

AN ACT GENERALLY REVISING UTILIZATION REVIEW LAWS; ESTABLISHING REQUIREMENTS FOR INDIVIDUALS MAKING OR REVIEWING ADVERSE DETERMINATIONS; PROVIDING FOR QUALIFICATIONS OF INDIVIDUALS MAKING OR REVIEWING ADVERSE DETERMINATIONS; REVISING A DEFINITION; AMENDING SECTIONS 33-32-102 AND 33-32-107, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.