SENATE BILL No. 1244

May 4, 2006, Introduced by Senators HAMMERSTROM and BIRKHOLZ and referred to the Committee on Health Policy.

A bill to amend 2000 PA 251, entitled

"Patient's right to independent review act,"

by amending section 3 (MCL 550.1903).

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3. As used in this act:

(a) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

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

(c) "Authorized representative" means any of the following:

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(*i*) A person to whom a covered person has given express written consent to represent the covered person in an external review.

(*ii*) A person authorized by law to provide substituted consent for a covered person.

(*iii*) If the covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional.

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

(e) "Certification" means a determination by a health carrier or its designee 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 carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

(f) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(g) "Commissioner" means the commissioner of the office of financial and insurance services.

(h) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(i) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a

health benefit plan.

(j) "Covered person" means a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan.

(k) "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 following discharge from a facility.

(*l*) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(m) "Expedited internal grievance" means an expedited grievance under section 2213(1)(*l*) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

(n) "Facility" or "health facility" means:

(*i*) A facility or agency licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e, or a licensed part thereof.

(*ii*) A psychiatric hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities operated by the department of community health or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a

freestanding hemodialysis unit.

(*v*) An ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance abuse treatment program licensed under parts 61 to 65 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(o) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of covered health care services.

(p) "Health care professional" means a person licensed, certified, or registered under parts 61 to 65 or 161 to 183 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523, and MCL 333.16101 to 333.18311.

(q) "Health care provider" or "provider" means a health care professional or a health facility.

(r) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(s) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit

health care corporation, or any other entity providing a plan of health insurance, health benefits, or health services. Health carrier does not include a state department or agency **ADMINISTERING A PLAN OF MEDICAL ASSISTANCE UNDER THE SOCIAL WELFARE ACT, 1939 PA 280, MCL 400.1 TO 400.119B. HEALTH CARRIER INCLUDES AN ENTITY THAT CONTRACTS OR OFFERS TO CONTRACT TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES COVERED UNDER A PLAN ESTABLISHED OR MAINTAINED BY A STATE OR LOCAL UNIT OF GOVERNMENT FOR ITS EMPLOYEES.**

(t) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to 1 or more of the following:

(*i*) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.

(*ii*) The provision of health care services to an individual.

(*iii*) Payment for the provision of health care services to an individual.

(u) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations.

(v) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

(w) "Protected health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(x) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but 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.

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

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

(aa) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health plans.