

## §2342. Review entities

**1. Licensure.** A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than \$400 and an annual license fee of not more than \$100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that Title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities. [PL 1995, c. 332, Pt. M, §3 (AMD).]

**2. Listing.** The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section. [PL 1989, c. 556, Pt. C, §1 (NEW).]

**3. Information required.** Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

- A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State; [PL 1989, c. 556, Pt. C, §1 (NEW).]
- B. The process used by the entity for addressing beneficiary or provider complaints; [PL 1989, c. 556, Pt. C, §1 (NEW).]
- C. The types of utilization review programs offered by the entity, such as:
  - (1) Second opinion programs;
  - (2) Prehospital admission certification;
  - (3) Preinpatient service eligibility determination; or
  - (4) Concurrent hospital review to determine appropriate length of stay; and [PL 1989, c. 556, Pt. C, §1 (NEW).]
- D. The process chosen by the entity to preserve beneficiary confidentiality of medical information. [PL 1989, c. 556, Pt. C, §1 (NEW).]

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.

[PL 1991, c. 200, Pt. A, §1 (AMD).]

**4. Transition for existing entities.** Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services. [PL 1989, c. 556, Pt. C, §1 (NEW).]

## SECTION HISTORY

PL 1989, c. 556, §C1 (NEW). PL 1989, c. 878, §B21 (AMD). PL 1991, c. 200, §A1 (AMD). PL 1993, c. 602, §1 (AMD). PL 1995, c. 332, §M3 (AMD).

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