§210. MEDICAL UTILIZATION REVIEW

1. **Rules.** The board, in consultation with the appropriate professional organization representing the health care specialty involved, shall adopt rules establishing specific protocols pertaining to the extent and duration of treatment for specific injuries and illnesses.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

2. **Utilization review.** For purposes of this section, "utilization review" means the initial prospective, concurrent or retrospective evaluation by an insurance carrier, self-insurer or group self-insurer of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on medically accepted standards. Utilization review requires the acquisition of necessary records, medical bills and other information concerning any health care or health services.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

3. **Review.** Utilization review must be performed by an insurance carrier, self-insurer or group self-insurer pursuant to a system established by the board that identifies the range of utilization of health care and health services.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

4. **Certification of insurance carrier.** An insurance carrier that complies with criteria or standards established by the board must be certified by the board.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

5. **Consent of health care provider.** By accepting payment under this chapter, a health facility or health care provider is deemed to have consented to submitting necessary records and other information concerning any health care or health services provided for utilization review pursuant to this section and to have agreed to comply with any decision of the board pursuant to this section.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

6. **Explanation of care or services.** If a health facility or health care provider provides health care or a health service that is not usually associated with, is longer in duration in time than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the insurance carrier, self-insurer or group self-insurer to explain the necessity or the reasons why in writing.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

7. **Excessive charges, unjustified treatment.** If an insurance carrier, self-insurer or group self-insurer determines that a health facility or health care provider has made any excessive charges or required unjustified treatment, hospitalization or visits, the health facility or health care provider may not receive payment under this chapter from the insurance carrier, self-insurer or group self-insurer for the excessive fees or unjustified treatment, hospitalization or visits, and is liable to return to the insurance carrier any such fees or charges already collected. The board may review the records and medical bills of any health facility

or health care provider with regard to a claim that an insurance carrier, self-insurer or group self-insurer has determined is not in compliance with the schedule of charges or requires unjustified treatment, hospitalization or office visits.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

8. **Inappropriate services.** If an insurance carrier determines that a health facility or health care provider improperly overutilized or otherwise rendered or ordered inappropriate health care or health services, or that the cost of the care or services was inappropriate, the health facility or health care provider may appeal to the board regarding that determination pursuant to procedures provided for under the system of utilization review.

[1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF) .]

9. **Penalties.** Any health facility or health care provider that knowingly submits false or misleading records or other information to an insurance carrier, self-insurer or group self-insurer or the board is guilty of a Class D crime.

[1993, c. 261, §1 (AMD) .]

SECTION HISTORY
1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF). 1993, c. 261, §1 (AMD).

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