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1	SENATE BILL NO. 447			
2	INTRODUCED BY V. RICCI, C. SCHOMER, C. HINKLE, J. ETCHART, L. DEMING, J. KARLEN			
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4	A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATED TO PRIOR AUTHORIZATION;			
5	EXTENDING THE LENGTH OF A PRIOR AUTHORIZATION CERTIFICATION; PROVIDING THAT A PRIOR			
6	AUTHORIZATION FOR TREATMENT OF A CHRONIC CONDITION IS VALID FOR THE DURATION OF THE			
7	CONDITION; PROHIBITING PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTIONS; PROVIDING			
8	DEFINITIONS; AND AMENDING SECTIONS 33-32-102, 33-32-107, AND 33-32-221, MCA."			
9				
10	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:			
11				
12	Section 1. Section 33-32-102, MCA, is amended to read:			
13	"33-32-102. Definitions. As used in this chapter, the following definitions apply:			
14	(1) "Adverse determination", except as provided in 33-32-402, means:			
15	(a) a determination by a health insurance issuer or its designated utilization review organization			
16	that, based on the provided information and after application of any utilization review technique, a requested			
17	benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not			
18	made in whole or in part for the requested benefit because the requested benefit does not meet the health			
19	insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level			
20	of effectiveness or is determined to be experimental or investigational;			
21	(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a			
22	requested benefit based on a determination by a health insurance issuer or its designated utilization review			
23	organization of a person's eligibility to participate in the health insurance issuer's health plan;			
24	(c) any prospective review or retrospective review of a benefit determination that denies, reduces,			
25	or terminates or fails to provide or make payment in whole or in part for a benefit; or			
26	(d) a rescission of coverage determination.			
27	(2) "Ambulatory review" means a utilization review of health care services performed or provided in			



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- 2 (3) "Authorized representative" means:
- 3 (a) a person to whom a covered person has given express written consent to represent the4 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.
- 27 (9)(10) "Cost sharing" means the share of costs that a covered member pays under the health



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1 insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or 2 similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the 3 cost of noncovered services. 4 (10)(11)"Covered benefits" or "benefits" means those health care services to which a covered person is 5 entitled under the terms of a health plan. 6 (11)(12)"Covered person" means a policyholder, a certificate holder, a member, a subscriber, an 7 enrollee, or another individual participating in a health plan. 8 (12)(13)"Discharge planning" means the formal process for determining, prior to discharge from a 9 facility, the coordination and management of the care that a patient receives after discharge from a facility. 10 (13)(14)"Emergency medical condition" has the meaning provided in 33-36-103. 11 (14)(15)"Emergency services" has the meaning provided in 33-36-103. 12 (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 13 14 has been upheld by a health insurance issuer or its designated utilization review organization at the completion 15 of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3. 16 (17)(18)"Grievance" means a written complaint or an oral complaint if the complaint involves an urgent 17 care request submitted by or on behalf of a covered person regarding: 18 (a) availability, delivery, or quality of health care services, including a complaint regarding an 19 adverse determination made pursuant to utilization review; 20 claims payment, handling, or reimbursement for health care services; or (b) 21 matters pertaining to the contractual relationship between a covered person and a health (c) 22 insurance issuer. 23 (18)(19)"Health care provider" or "provider" means a person, corporation, facility, or institution licensed 24 by the state to provide, or otherwise lawfully providing, health care services, including but not limited to: 25 (a) a physician, physician assistant, advanced practice registered nurse, health care facility as 26 defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, 27 psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed



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- 2 (b) an officer, employee, or agent of a person described in subsection (18)(a) (19)(a) acting in the 3 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, chronic condition, illness, injury, or disease or its symptoms or comorbidities, including minimizing the progression, symptoms, or comorbidities of a health condition, chronic condition, illness, injury, or disease, 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 <u>economic benefit of the insurer or</u> 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.
- 26 (24)(25)"Person" means an individual, a corporation, a partnership, an association, a joint venture, a 27 joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in



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1	this subsection.		
2	(25)(26)"Preservice claim" means a request for benefits or payment from a health insurance issuer f		
3	health care services that, under the terms of the health insurance issuer's contract of coverage, requires		
4	authorization from the health insurance issuer or from the health insurance issuer's designated utilization review		
5	organization prior to receiving the services.		
6	(26)(27)"Prospective review" means a utilization review, MEDICAL NECESSITY REVIEW, OR PRIOR		
7	AUTHORIZATION conducted of a preservice claim prior to an admission or a course of treatment.		
8	(27)(28)(a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan		
9	that has a retroactive effect.		
10	(b) The term does not include a cancellation or discontinuance under a health plan if the		
11	cancellation or discontinuance of coverage:		
12	(i) has only a prospective effect; or		
13	(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a		
14	failure to timely pay required premiums or contributions toward the cost of coverage.		
15	(28)(29)(a) "Retrospective review" means a review of medical necessity conducted after services have		
16	been provided to a covered person.		
17	(b) The term does not include the review of a claim that is limited to an evaluation of		
18	reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.		
19	(29)(30) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a		
20	health care provider other than the one originally making a recommendation for a proposed health care service		
21	to assess the clinical necessity and appropriateness of the initial proposed health care service.		
22	(30)(31)"Stabilize" means, with respect to an emergency condition, to ensure that no material		
23	deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the		
24	transfer of the individual from a facility.		
25	(31)(32)(a) "Urgent care request" means a request for a health care service or course of treatment with		



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seriously jeopardize the life or health of the covered person or the ability of the covered person

respect to which the time periods for making a nonurgent care request determination could:

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- (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)(e) (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
- 22 (d) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, 23 medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract."
 - **Section 2.** Section 33-32-107, MCA, is amended to read:
 - "33-32-107. Length of prior authorization. (1) A Except as provided in subjection (2), certification by a utilization review organization approving health care services is valid for at least 3 12 months from the date



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the health care provider receives the certification unless the covered person loses coverage under the applicable health plan or health insurance coverage.

(2) A certification by a utilization review organization approving a health care service for treatment of a chronic condition is valid for the duration of the condition. The utilization review organization may not require the covered person to obtain certification again for the same health care service. The utilization review organization may require documentation that the chronic condition remains present no more frequently than every 12 months."

- Section 3. Section 33-32-221, MCA, is amended to read:
- "33-32-221. Prior authorization requirements. (1) A health insurance issuer or an entity that a health insurance issuer IT contracts with to perform a prior authorization on the health insurance issuer's ITS behalf may not perform prior authorization on benefits for:
- (a) any generic prescription drug that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the covered drug at the same quantity without interruption for 6 months;
- (b) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication for the same drug if the covered person has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the prescription drug or drugs was approved;
- (c) any prescription drug, generic or brand name, solely because the dosage of the medication for the covered person has been adjusted by the prescriber of the prescription drug, as long as the dosage is within the dosage approved by the food and drug administration or is consistent with clinical dosing for the medication; er
 - (d) any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic:
- (e) controlled substances found at 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32 AND ANY FORMULARY ORAL OR INHALED NONBIOLOGIC GENERIC PRESCRIPTION DRUG



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1 THAT IS NOT LISTED AS A SPECIALTY TIER DRUG BY MEDICARE PART D, OR WITHIN ANY OF THE SCHEDULES OF 2 CONTROLLED SUBSTANCES FOUND AT 21 CFR 1308.11 THROUGH 21 CFR 1308.15 OR THE SCHEDULES OF 3 CONTROLLED SUBSTANCES FOUND IN TITLE 50, CHAPTER 32; 4 (f)(E) any prescription drug, generic or brand name, prescribed for treatment of a substance use 5 disorder, provided that the prescription does not exceed the U.S. food and drug administration labeled dosages; 6 or 7 (g)(F) AT LEAST ONE PRESCRIPTION DRUG OPTION APPROPRIATE FOR CHILDREN AND ONE APPROPRIATE FOR 8 ADULTS, WITHIN EACH any of the following prescription drugs DRUG THERAPEUTIC CLASSES, generic or brand name, 9 except as provided in subsection (3): 10 (i) an inhaled corticosteroid; 11 (ii) an inhaled short-acting beta-agonist; 12 (iii) an inhaled combination corticosteroid and beta-agonist: 13 (iv) a short-acting insulin for diabetes; or 14 a long-acting insulin for diabetes. (v) (3) If an individual has multiple prescriptions for any one kind of prescription drug listed under 15 16 subsection (1)(g), a health insurance issuer or its utilization review organization may perform a prior 17 authorization on all but one prescription. If the health insurance issuer or its utilization review organization makes an adverse 18 19 determination for a prescription drug during prior authorization, the health insurance issuer or its utilization 20 review organization shall provide a written adverse determination notice that includes a list of reasonable 21 therapeutic alternatives that are covered by the insurer's formulary. 22 Any adverse determination for a prescription drug made during prior authorization by a (2)(5)(4)23 health insurance issuer must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that 24 25 does not result in an adverse determination does not require the involvement of a physician on the part of a 26 health insurance issuer."



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1	COORDINA	ATION SECTION. Section 4. Coord	dination instruction. If both House Bill No. 398 and	
2	[this act] are passed and approved and if both contain a section that amends 33-22-102, then the sections			
3	amending 33-22-102 are void and 33-22-102 must be amended as follows:			
4	"33-32-102.	. Definitions. As used in this chapte	er, the following definitions apply:	
5	(1) "Ad	lverse determination", except as prov	ided in 33-32-402, means:	
6	(a) a de	etermination by a health insurance is	suer or its designated utilization review organization	
7	that, based on the p	provided information and after applica	tion of any utilization review technique, a requested	
8	benefit under the he	ealth insurance issuer's health plan is	denied, reduced, or terminated or that payment is not	
9	made in whole or in	part for the requested benefit because	se the requested benefit does not meet the health	
10	insurance issuer's re	equirement for medical necessity, ap	propriateness, health care setting, level of care, or leve	
11	of effectiveness or is	s determined to be experimental or in	vestigational;	
12	(b) a de	enial, reduction, termination, or failure	e to provide or make payment in whole or in part for a	
13	requested benefit ba	ased on a determination by a health i	nsurance issuer or its designated utilization review	
14	organization of a pe	erson's eligibility to participate in the h	ealth insurance issuer's health plan;	
15	(c) any	prospective review or retrospective	review of a benefit determination that denies, reduces,	
16	or terminates or fails	s to provide or make payment in who	e or in part for a benefit; or	
17	(d) a re	escission of coverage determination.		
18	(2) "Am	nbulatory review" means a utilization	review of health care services performed or provided in	
19	an outpatient setting	j .		
20	(3) "Au	thorized representative" means:		
21	(a) a pe	erson to whom a covered person has	given express written consent to represent the	
22	covered person;			
23	(b) a pe	erson authorized by law to provided s	substituted consent for a covered person; or	
24	(c) a fa	amily member of the covered person,	or the covered person's treating health care provider,	
25	only if the covered p	person is unable to provide consent.		
26	(4) "Ca	se management" means a coordinat	ed set of activities conducted for individual patient	
27	management of seri	ious, complicated, protracted, or othe	rwise complex health conditions.	



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1	(5)	"Certification" means a determination by a health insurance issuer or its designated utilization
2	review organiza	ation that an admission, availability of care, continued stay, or other health care service has been
3	reviewed and, I	pased on the information provided, satisfies the health insurance issuer's requirements for
4	medical necess	sity, appropriateness, health care setting, level of care, and level of effectiveness.
5	<u>(6)</u>	"Chronic condition" means a condition that lasts 1 year or more and that requires ongoing
6	medical attention	on or limits activities of daily living.
7	(6) (7)	"Clinical peer" means a physician or other health care provider who:
8	(a)	holds a nonrestricted license in a state of the United States; and
9	(b)	is trained or works in the same or a similar specialty to the specialty that typically manages the
10	medical conditi	on, procedure, or treatment under review.
11	(7) (8)	"Clinical review criteria" means the written policies, written screening procedures, decision
12	abstracts, deter	rmination rules, clinical and medical protocols, practice guidelines, or any other criteria or
13	rationale used l	by a health insurance issuer or its designated utilization review organization to determine the
14	medical necess	sity of health care services.
15	(8) (9)	"Concurrent review" means a utilization review conducted during a patient's stay or course of
16	treatment in a f	acility, the office of a health care professional, or another inpatient or outpatient health care
17	setting.	
18	(9) (10)	"Cost sharing" means the share of costs that a covered member pays under the health
19	insurance issue	er's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or
20	similar charges	, but does not include premiums, balance billing amounts for out-of-network providers, or the
21	cost of noncove	ered services.
22	(10) (11)"Covered benefits" or "benefits" means those health care services to which a covered person is
23	entitled under t	he terms of a health plan.
24	(11) (12	"Covered person" means a policyholder, a certificate holder, a member, a subscriber, an
25	enrollee, or and	other individual participating in a health plan.
26	(12) (13	"Discharge planning" means the formal process for determining, prior to discharge from a
27	facility, the coo	rdination and management of the care that a patient receives after discharge from a facility.



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1	(13)(14)"Emergency medical condition" has the meaning provided in 33-36-103.			
2	(14)(15)"Emergency services" has the meaning provided in 33-36-103.			
3	(15)(16)"External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.			
4	(16)(17)"Final adverse determination" means an adverse determination involving a covered benefit that			
5	has been upheld by a health insurance issuer or its designated utilization review organization at the completion			
6	of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.			
7	(17)(18) "Grievance" means a written complaint or an oral complaint if the complaint involves an urgent			
8	care request submitted by or on behalf of a covered person regarding:			
9	(a) availability, delivery, or quality of health care services, including a complaint regarding an			
10	adverse determination made pursuant to utilization review;			
11	(b) claims payment, handling, or reimbursement for health care services; or			
12	(c) matters pertaining to the contractual relationship between a covered person and a health			
13	nsurance issuer.			
14	(18)(19) "Health care provider" or "provider" means a person, corporation, facility, or institution licensed			
15	by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:			
16	(a) a physician, physician assistant, advanced practice registered nurse, health care facility as			
17	defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist,			
18	psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed			
19	professional counselor; and			
20	(b) an officer, employee, or agent of a person described in subsection (18)(a) (19)(a) acting in the			
21	course and scope of employment.			
22	(19)(20)"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of			
23	a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or			
24	durable medical equipment.			
25	(20)(21)"Health insurance issuer" has the meaning provided in 33-22-140.			
26	(21)(22)"Medical necessity" means health care services that a health care provider exercising prudent			
27	clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating,			



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ı	curing, or relieving a fleatiff condition, <u>chronic condition,</u> limess, injury, or disease or its symptoms <u>or</u>			
2	comorbidities, including minimizing the progression, symptoms, or comorbidities of a health condition, chronic			
3	condition, illnes	s, injury, or disease, and that are:		
4	(a)	in accordance with generally accepted standards of practice;		
5	(b)	clinically appropriate in terms of type, frequency, extent, site, and duration and are considered		
6	effective for the	patient's illness, injury, or disease; and		
7	(c)	not primarily for the economic benefit of the insurer or the convenience of the patient or health		
8	care provider a	nd not more costly than an alternative service or sequence of services at least as likely to		
9	produce equiva	lent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness,		
10	injury, or diseas	se.		
11	(22) (23	"Network" means the group of participating providers providing services to a managed care		
12	plan.			
13	(23) (24	Participating provider" means a health care provider who, under a contract with a health		
14	insurance issue	er or with its contractor or subcontractor, has agreed to provide health care services to covered		
15	persons with the	e expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly		
16	or indirectly from	m the health insurance issuer.		
17	(24) (25	Person" means an individual, a corporation, a partnership, an association, a joint venture, a		
18	joint stock comp	pany, a trust, an unincorporated organization, or any similar entity or combination of entities in		
19	this subsection.			
20	(25) (26	Preservice claim" means a request for benefits or payment from a health insurance issuer for		
21	health care serv	vices that, under the terms of the health insurance issuer's contract of coverage, requires		
22	authorization fro	om the health insurance issuer or from the health insurance issuer's designated utilization review		
23	organization pri	or to receiving the services.		
24	(26) (27	Prospective review" means a utilization review, medical necessity review, or prior authorization		
25	conducted of a	preservice claim prior to an admission or a course of treatment.		
26	(27) (28	(a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan		
27	that has a retro	active effect.		



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1	(b)	The term does not include a cancellation of discontinuance under a health plan if the
2	cancellation or	discontinuance of coverage:
3	(i)	has only a prospective effect; or
4	(ii)	is effective retroactively to the extent that the cancellation or discontinuance is attributable to a
5	failure to timely	pay required premiums or contributions toward the cost of coverage.
6	(28) (29	(a) "Retrospective review" means a review of medical necessity conducted after services have
7	been provided	to a covered person.
8	(b)	The term does not include the review of a claim that is limited to an evaluation of
9	reimbursement	levels, veracity of documentation, accuracy of coding, or adjudication for payment.
10	(29) (30	"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a
11	health care pro	vider other than the one originally making a recommendation for a proposed health care service
12	to assess the c	linical necessity and appropriateness of the initial proposed health care service.
13	(30) (31)"Stabilize" means, with respect to an emergency condition, to ensure that no material
14	deterioration of	the condition is, within a reasonable medical probability, likely to result from or occur during the
15	transfer of the i	ndividual from a facility.
16	(31) (32	(a) "Urgent care request" means a request for a health care service or course of treatment with
17	respect to whic	h the time periods for making a nonurgent care request determination could:
18	(i)	seriously jeopardize the life or health of the covered person or the ability of the covered person
19	to regain maxir	num function; or
20	(ii)	subject the covered person, in the opinion of a health care provider with knowledge of the
21	covered persor	's medical condition, to severe pain that cannot be adequately managed without the health care
22	service or treat	ment that is the subject of the request.
23	(b)	Except as provided in subsection (31)(c) (32)(c), in determining whether a request is to be
24	treated as an u	rgent care request, an individual acting on behalf of the health insurance issuer shall apply the
25	judgment of a p	orudent lay person who possesses an average knowledge of health and medicine.
26	(c)	Any request that a health care provider with knowledge of the covered person's medical
27	condition deter	mines is an urgent care request within the meaning of subsection (31)(a)(32)(a) must be treated



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1	as an urgent care request.			
2	(32)(33)"Utilization review" means a set of formal techniques designed to monitor the use of or to			
3	evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or			
4	settings. Techniques may include ambulatory review, prospective review, second opinions, certification,			
5	concurrent review, case management, discharge planning, or retrospective review.			
6	(33)(34)"Utilization review organization" means an entity that conducts utilization review for one or			
7	more of the following:			
8	(a) an employer with employees who are covered under a health benefit plan or health insurance	è		
9	policy;			
10	(b) a health insurance issuer providing review for its own health plans or for the health plans of			
11	another health insurance issuer;			
12	(c) a preferred provider organization or health maintenance organization; and			
13	(d) any other individual or entity that provides, offers to provide, or administers hospital, outpatier	nt,		
14	medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract	t."		
15				
16	COORDINATION SECTION. Section 5. Coordination instruction. (1) If both House Bill 398 and			
17	[this act] are passed and approved and if both contain a section that amends 33-22-107, then [section 4 of			
18	House Bill No. 398], amending 33-32-107, is void.			
19	(2) If both House Bill No. 399 and [this act] are passed and approved and if both contain a section	n		
20	that amends 33-22-221, then [section 3 of this act], amending 33-22-221, is void.			
21				



22

- END -