PROPOSED AMENDMENTS TO SENATE BILL NO. 2302

Page 1, line 1, remove "subsection 7 of" and after "26.1-26.4-02" insert ", subsection 1 of section 26.1-26.4-04, subdivision c of subsection 4 of section 26.1-26.4-04, and subsection 10 of section 26.1-26.4-04"

Page 1, line 2, replace "the definition" with "retroactive reviews as part"

Page 1, line 4, replace "Subsection 7 of section" with "Section"

Page 1, replace lines 6 through 10 with:

"**26.1-26.4-02. Definitions.** For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the insurance commissioner.

2. "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

3. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

4. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

5. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

6. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

7. <u>"Retrospective" means utilization review of medical necessity which is 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.</u>

<u>8.</u> "Utilization review" means a system for prospective<u>, retrospective,</u> and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance

regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

~~8.~~ 9. "Utilization review agent" means any person or entity performing utilization review, except:

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

SECTION 2. AMENDMENT. Subsection 1 of section 26.1-26.4-04 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. Notification of a determination by the utilization review agent must be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review. In the case of a retrospective review, the utilization review agent has five business days after receipt of all information necessary to complete the review to notify the provider of record, enrollee, or appropriate individual.

SECTION 3. AMENDMENT. Subdivision c of subsection 4 of section 26.1-26.4-04 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

c. Utilization review agents shall provide for an expedited appeals process for emergency or life-threatening situations. Utilization review agents shall complete the adjudication of expedited appeals within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal. The expedited appeals process is not applicable to retrospective reviews.

SECTION 4. AMENDMENT. Subsection 10 of section 26.1-26.4-04 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

10. When an initial appeal to reverse a determination is unsuccessful, a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate. Subsequent determinations for retrospective reviews must be completed no later than thirty days from the date the appeal is filed and all information necessary to complete the appeal is received."

Renumber accordingly