Fifty-ninth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2282

Introduced by

Senators Brown, Heitkamp, Lyson

Representatives Nelson, Price

A BILL for an Act to create and enact a new section to chapter 26.1-26.4 of the North Dakota Century Code, relating to independent review procedures for health care utilization review agents; to amend and reenact sections 26.1-26.4-02, 26.1-26.4-04, and 65-02-20 of the North Dakota Century Code, relating to minimum standards of utilization review agents and workforce safety and insurance procedures for dispute resolution; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-26.4-02 of the North Dakota Century Code is amended and reenacted as follows:

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

1. "Adverse decision" means a utilization review determination by a health care insurer that a proposed or delivered health care service that would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and if the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services or the adverse decision is the reason for the insured not receiving the requested services.
2. "Commissioner" means the insurance commissioner.
~~2.~~ 3. "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.~~ 4. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

~~4.~~ 5. "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.

6. "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. The entity may include the federally designated state peer review organization or other entity that has experience serving as an external quality review organization in health programs administered by the state or be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state who are qualified and credentialed with respect to the health care service review. If no providers in this state are qualified and credentialed with respect to the review of any case, the external review organization may employ health care providers who actively engage in such health care provider's practice outside the state.

~~5.~~ 7. "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.~~ 8. "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.~~ 9. "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.

~~8.~~ 10. "Utilization review" means a system for prospective, retrospective, 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.

~~9.~~ 11. "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. Section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-04. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.
2. Any determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.
3. Any notification of a determination not to certify an admission or service or procedure must include the information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.
4. Utilization review agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the utilization review agent. The appeal procedure must provide for the following:

a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be made by a physician or, if appropriate, a licensed psychologist.

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.

c. Utilization review agents shall provide for an expedited appeals process complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1.

5. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.

6. Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.

7. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

9. When conducting utilization review or making a benefit determination for emergency services:

a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.

b. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

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.

11. The commissioner shall adopt rules establishing external review procedures pursuant to section 3 of this Act to address disputes between a provider of record or enrollee and the utilization review agent over adverse utilization review determinations regarding coverage of services or the medical necessity of a covered admission, service, or procedure, including review of dispute resolution decisions affecting medical providers under section 65-02-20. For purposes of this subsection and notwithstanding section 26.1-26.4-02, a utilization review agent includes the department of human services in administration of the medical assistance program. This subsection does not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner by rule, coverage under a plan through medicare or the federal employees health benefits program, any coverage issued as a supplement to liability insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket, or individual basis.

12. ~~However, the~~ The commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization and the utilization review accreditation organization requires adherence to standards that are comparable to this section. However, the utilization review agent must strictly comply with the independent review requirements of subsection 11 and emergency services requirements of subsection 9.

SECTION 3. A new section to chapter 26.1-26.4 of the North Dakota Century Code is created and enacted as follows:

External review.

1. The commissioner, or the commissioner's designee, shall:

a. Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health care insurer;

b. Allow the enrollee or provider of record filing a request for external review to provide additional written information as may be relevant for the commissioner to make a decision on whether the request qualifies for external review;

c. Make a decision on a request for external review within ten business days after receiving all necessary information;

d. Notify the insured, provider of record, and health care insurer in writing whether a request for external review will or will not be granted;

e. Design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision; and

f. Determine appropriate fees to be charged a provider of record for external review, including reimbursement of those fees by the health care insurer if the provider of record prevails in the decision made by the external review organization. An insured may not be assessed a fee for external review.

2. The external review organization shall provide that all reviews completed are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the performance of the external review organization's duties.

3. The external review organization shall issue a written decision to the insured or provider of record and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within thirty business days. The standard of review must be whether the health care service denied by the health care insurer was medically necessary and a covered service under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review must be whether the health care service denied by the health care insurer was covered or excluded from coverage under the terms of the insured's contract. The right to external review may not be construed to change the terms of coverage under a health insurance plan or insurance policy.

4. The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues within seven business days.

5. The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

6. No external review organization nor any individual working on behalf of such an organization is liable in damages to any insured or health care insurer for any opinion rendered as part of an external review conducted pursuant to this chapter.

7. The external review organization shall maintain confidentiality of the medical records of the insured in accordance with state and federal law.

SECTION 4. AMENDMENT. Section 65-02-20 of the North Dakota Century Code is amended and reenacted as follows:

65-02-20. Organization to establish managed care program. The organization shall establish a managed care program, including utilization review and bill review, to effect the best medical solution for an injured employee in a cost-effective manner upon a finding by the organization that the employee suffered a compensable injury. The program shall operate according to guidelines adopted by the organization and shall provide for medical management of claims within the bounds of workforce safety and insurance law. Information compiled and analysis performed pursuant to a managed care program which relate to patterns of treatment, cost, or outcomes by health care providers are confidential and are not open to public inspection to the extent the information and analysis identify a specific health care provider, except to the specific health care provider, organization employees, or persons rendering assistance to the organization in the administration of this title. If an employee, employer, or medical provider disputes a managed care decision, the employee, employer, or medical provider shall request binding dispute resolution on the decision. The organization shall make rules providing for the procedures for dispute resolution. Dispute resolution under this section is not subject to chapter 28-32 or section 65-01-16. A dispute resolution decision under this section requested by a medical provider concerning payment for medical treatment already provided or a request for diagnostic tests or treatment is not reviewable by any court but is reviewable under rules adopted by the insurance commissioner for independent review under

subsection 11 of section 26.1-26.4-04. A dispute resolution decision under this section requested by an employee is reviewable by a court only if medical treatment has been denied to the employee. A dispute resolution decision under this section requested by an employer is reviewable by a court only if medical treatment is awarded to the employee. The dispute resolution decision may be reversed only if the court finds that there has been an abuse of discretion in the dispute resolution process. Any person providing binding dispute resolution services under this section is exempt from civil liability relating to the binding dispute resolution process and decision.

SECTION 5. EFFECTIVE DATE. This Act becomes effective January 1, 2006.