Sixty-first
Legislative Assembly
of North Dakota

SENATE BILL NO. 2397

Introduced by

Senators Klein, Horne

Representative Svedjan

A BILL for an Act to create and enact two new sections to chapter 26.1-04 of the North Dakota Century Code, relating to health insurance contracting practices; and to amend and reenact subsection 2 of section 26.1-36-41 of the North Dakota Century Code, relating to health care provider profiling.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-04 of the North Dakota Century Code is created and enacted as follows:

Unfair contracting practices.

1. A person that contracts with a health care provider shall comply with this section. A contract in existence before August 1, 2009, that is renewed or renews by its terms must comply with this section by January 1, 2010. Any contract provision that conflicts with this section, section 26.1-04-03, or any other contract limitations imposed on an entity by this title is deemed an unfair contracting provision and is void.
2. The commissioner shall:
   a. Review each contract to ensure conformity with fair contracting principles;
   b. Approve contracts that comply with fair contracting laws; and
   c. Enforce fair contracting laws through fines and injunction.
3. As used in this section, the following definitions apply in addition to the definitions in subsection 14 of section 26.1-04-03:
   a. "Edit" means a practice or procedure pursuant to which one or more adjustments are made regarding procedure codes, including the American medical association's procedural terminology code and the centers for

medicare and medicaid services health care common procedure coding system, that results in:

(1) Payment for some, but not all of the codes originally billed;

(2) Payment for a different procedure code than the procedure code originally billed;

(3) A reduced payment as a result of services provided to a patient under more than one code on the same service date;

(4) A reduced payment related to a modifier used with a procedure code; or

(5) A reduced payment based on multiple units of the same code billed for a single date of service.

b. "Material change" means a change to a contract which decreases the health care provider's payment or compensation for medical services or reimbursement for medical goods or which changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense.

4. Each contract clearly must provide:

a. The terms governing the specific manner of compensation and payment.

b. The fee schedule for inpatient and outpatient services and for procedure codes reasonably expected to be billed.

c. The methodology used to calculate any fee schedule, such as coding practice or relative value unit system and conversion factor, percentage of medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure must include the name of any coding practices; relative value system; its version, edition, or publication date; and any applicable conversion or geographic factor.

d. The effects of edits, adjustments, and fee schedule amendments, if any, on payment or compensation which may be satisfied by providing the information via a readily available mechanism, such as a website. A health care payer may not combine any individually submitted coded services unless such action conforms with the American medical association's current procedural terminology coding guideline in effect on the date of service, including the use

of current procedural terminology modifiers, add-on codes, and modifier fifty-one exempt codes, and in accordance with contractually agreed-upon bundling practices and policies.

5. A health care provider must be given an opportunity to terminate the contract before a material change to the contract becomes effective, and a health care payer shall disclose to the provider any material change in contract terms at least sixty days before the effective date of change. The contract may not allow the entity to add, modify, or delete material terms of the contract without the consent of the health care provider, including the scope of medical management, the amount and manner of payment, and other terms of the contract determined by the commissioner to be material terms.

6. Before terminating a contract with a health care provider, the entity shall provide written reasons for the termination and provide a reasonable review mechanism, except in a case involving imminent harm to the patient's health, action by a state medical or physician licensing board or other government agency that effectively impairs the provider's ability to provide medical services, or fraud. The review mechanism must be conducted in a timely manner and must incorporate an advisory peer review panel. In the case of a physician, the peer review panel must be composed of three members, including one member who is a practitioner in the same or similar specialty as the affected practitioner.

7. An entity that credentials providers shall request credentialing information in a uniform format that includes data commonly requested and, absent good cause stated in writing, shall complete the credentialing process within forty-five days of receipt of a completed application. Immediately after the health care provider becomes credentialed, the entity shall retroactively compensate the provider for services rendered from the date of the provider's application.

8. An entity may not retroactively deny reimbursement to health care providers after the six-month period from the date the entity paid the claim submitted by the provider. A claim retroactively denied within the six-month period must be justified to the provider in writing, and if the claim results from coordination of benefits, the written statement must provide the name and address of the entity acknowledging

responsibility for payment of the denied claim. Unless the claim is denied due to fraud, an entity that does not comply with this subsection may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to the health care provider by reducing payments currently owed to the health care provider, or withhold future reimbursement.

9. An entity may not require that a health care provider participate in one health care product as a condition to participation in another product. If an entity proposes to make a material change to the contract by addition of a new plan or product and the provider objects, the objection may not be the basis upon which the entity may terminate the contract.

10. An entity may not sell, rent, or give access to a health care provider's discounted rates to another entity unless explicitly authorized by the provider in writing, and the provider is not obligated to extend the discounted rate to any other entity.

SECTION 2. A new section to chapter 26.1-04 of the North Dakota Century Code is created and enacted as follows:

Private cause of action. The commissioner shall enforce the requirements of utilization review in section 26.1-26.4-04, independent external review in section 26.1-36-44, unfair methods of competition and unfair or deceptive acts or practices under section 26.1-04-03, and unfair contracting standards under section 26.1-04-03.1. A private right of action is created for a health care provider to remedy violations of these requirements, including:

1. Actions for damages;
2. Declaratory and injunctive relief; and
3. Reasonable attorney's fees if the health care provider is the prevailing party.

SECTION 3. AMENDMENT. Subsection 2 of section 26.1-36-41 of the North Dakota Century Code is amended and reenacted as follows:

2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice pattern, the entity shall provide upon request of the practitioner at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner. An entity may not sanction a

practitioner, terminate a practitioner's participating contract, or designate a practitioner as nonpayable on the basis of a practice profile without informing the practitioner of the specific data underlying those findings. For purposes of this section, a "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning the cost, quality, or quantity of services rendered by an individual practitioner, group of practitioners, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring practitioner performance shall:

a. Make severity adjustments, including allowances for the severity of illness or condition of the patient mix and allowances for patients with multiple illnesses or conditions;

b. Periodically evaluate, with input from specialty-specific practitioners as appropriate, the quality and accuracy of practice profiles, data sources, and methodologies;

c. Develop and implement safeguards to protect against the unauthorized use or disclosure of practice profiles; and

d. Provide the opportunity for any practitioner at any time to examine the accuracy, completeness, or validity of any practice profile concerning the practitioner and to prepare a written response to the profile. A profile ranking may not be based solely on cost, and must use national standards to measure quality and cost-efficiency, including measures endorsed by the national quality forum. The entity shall negotiate in good faith with the practitioner to correct any inaccuracies or to make the profile complete and shall provide a peer review appeal mechanism to resolve practitioner complaints. If the inaccuracies or deficiencies are not corrected to the satisfaction of the practitioner through the peer review appeal, the entity shall submit the written response prepared by the practitioner along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 26.1-36-12.4.