

Introduced by

Senators Meyer, Barta, Bekkedahl, Cleary

Representatives Nelson, Warrey

1 A BILL for an Act to create and enact chapter 26.1-36.12 of the North Dakota Century Code,  
2 relating to prior authorization for health and dental insurance.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1.** Chapter 26.1-36.12 of the North Dakota Century Code is created and enacted  
5 as follows:

6 **26.1-36.12-01. Definitions.**

7 As used in this chapter:

- 8 1. "Adverse determination" means a decision by a prior authorization review organization  
9 relating to an admission, extension of stay, or health care service that is partially or  
10 wholly adverse to the enrollee, including a decision to deny an admission, extension of  
11 stay, or health care service on the basis it is not medically necessary.
- 12 2. "Appeal" means a formal request, either orally or in writing, to reconsider an adverse  
13 determination regarding an admission, extension of stay, or health care service.
- 14 3. "Authorization" means a determination by a prior authorization review organization that  
15 a health care service has been reviewed and, based on the information provided,  
16 satisfies the prior authorization review organization's requirements for medical  
17 necessity and appropriateness, and payment will be made for that health care service.
- 18 4. "Clinical criteria" means the written policies, written screening procedures, drug  
19 formularies or lists of covered drugs, determination rules, determination abstracts,  
20 clinical protocols, practice guidelines, medical protocols, and any other criteria or  
21 rationale used by the prior authorization review organization to determine the  
22 necessity and appropriateness of health care services.
- 23 5. "Emergency health care services" means health care services, supplies, or treatments  
24 furnished or required to screen, evaluate, and treat an emergency medical condition.

- 1       6. "Emergency medical condition" means a medical condition that manifests itself by  
2       symptoms of sufficient severity which may include pain and that a prudent layperson  
3       who possesses an average knowledge of health and medicine could reasonably  
4       expect the absence of medical attention to result in placing the individual's health in  
5       jeopardy, impairment of a bodily function, or dysfunction of any body part.
- 6       7. "Enrollee" means an individual who has contracted for or who participates in coverage  
7       under a policy for that individual or that individual's eligible dependents.
- 8       8. "Health care services" means health care procedures, treatments, or services  
9       provided by a licensed facility or provided by a licensed physician, licensed dentist, or  
10       within the scope of practice for which a health care professional is licensed. The term  
11       includes dental services and the provision of pharmaceutical products or services or  
12       durable medical equipment.
- 13       9. "Medically necessary" as the term applies to health care services means health care  
14       services a prudent physician or dentist would provide to a patient for the purpose of  
15       preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a  
16       manner that is:
- 17       a. In accordance with generally accepted standards of medical practice;  
18       b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and  
19       c. Not primarily for the economic benefit of the health plans and purchasers or for  
20       the convenience of the patient, treating physician, treating dentist, or other health  
21       care provider.
- 22       10. "Medication assisted treatment" means the use of medications, commonly in  
23       combination with counseling and behavioral therapies, to provide a comprehensive  
24       approach to the treatment of substance use disorders. United States food and drug  
25       administration-approved medications used to treat opioid addiction include methadone  
26       and buprenorphine, alone or in combination with naloxone and extended-release  
27       injectable naltrexone. Types of behavioral therapies include individual therapy, group  
28       counseling, family behavior therapy, motivational incentives, and other modalities.
- 29       11. "Policy" means an insurance policy, a health maintenance organization contract, a  
30       health service corporation contract, an employee welfare benefits plan, a hospital or  
31       medical services plan, or any other benefits program providing payment.

1           reimbursement, or indemnification for health care costs. The term includes a dental  
2           benefit plan as defined in section 26.1-36.9-01. The term does not include medical  
3           assistance, benefits under title 65, or public employees retirement system health  
4           benefits.

5       12. "Prior authorization" means the review conducted before the delivery of a health care  
6       service, including an outpatient health care service, to evaluate the necessity,  
7       appropriateness, and efficacy of the use of health care services, procedures, and  
8       facilities, by a person other than the attending health care professional, for the  
9       purpose of determining the medical necessity of the health care services or admission.  
10       The term includes a review conducted after the admission of the enrollee and in  
11       situations in which the enrollee is unconscious or otherwise unable to provide advance  
12       notification. The term does not include a referral or participation in a referral process  
13       by a participating provider unless the provider is acting as a prior authorization review  
14       organization.

15       13. "Prior authorization review organization" means a person that performs prior  
16       authorization for:

17           a. An employer with employees in the state who are covered under a policy;

18           b. An insurer that writes policies;

19           c. A preferred provider organization or health maintenance organization; or

20           d. Any other person that provides, offers to provide, or administers hospital,  
21           outpatient, medical, prescription drug, or other health benefits to an individual  
22           treated by a health care professional in the state under a policy.

23       14. "Urgent health care service" means a health care service for which, in the opinion of a  
24       health care professional with knowledge of the enrollee's medical condition, the  
25       application of the time periods for making a non-expedited prior authorization might:

26           a. Jeopardize the life or health of the enrollee or the ability of the enrollee to regain  
27           maximum function; or

28           b. Subject the enrollee to pain that cannot be managed adequately without the care  
29           or treatment that is the subject of the prior authorization review.

1        **26.1-36.12-02. Disclosure and review of prior authorization requirements.**

2        1. A prior authorization review organization shall make any prior authorization  
3        requirements and restrictions readily accessible on the organization's website to  
4        enrollees, health care professionals, and the general public. Requirements include the  
5        written clinical criteria and be described in detail using plain and ordinary language  
6        comprehensible by a layperson.

7        2. If a prior authorization review organization intends to implement a new prior  
8        authorization requirement or restriction, or amend an existing requirement or  
9        restriction, the prior authorization review organization shall:

- 10       a. Ensure the new or amended requirement is not implemented unless the prior  
11       authorization review organization's website has been updated to reflect the new  
12       or amended requirement or restriction; and  
13       b. Provide contracted health care providers of enrollees written notice of the new or  
14       amended requirement or amendment no fewer than one hundred twenty days  
15       before the requirement or restriction is implemented.

16       **26.1-36.12-03. Personnel qualified to make adverse determinations.**

17       A prior authorization review organization shall ensure all adverse determinations are made  
18       by a licensed physician or licensed dentist. The reviewing individual:

- 19       1. Shall possess a valid nonrestricted license to practice medicine or dentistry;  
20       2. Must be of the same or similar specialty as the physician or dentist who typically  
21       manages the condition or illness or provides the health care service involved in the  
22       request;  
23       3. Must have experience treating patients with the condition or illness for which the  
24       health care service is being requested; and  
25       4. Shall make the adverse determination under the clinical direction of one of the prior  
26       authorization review organization's medical directors who is responsible for the health  
27       care services provided to enrollees.

28       **26.1-36.12-04. Consultation before issuing an adverse determination.**

29       If a prior authorization review organization is questioning the medical necessity of a health  
30       care service, the prior authorization review organization shall notify the enrollee's physician or  
31       dentist that medical necessity is being questioned. Before issuing an adverse determination, the

1 prior authorization review organization shall allow the enrollee's physician or dentist the  
2 opportunity to discuss the medical necessity of the health care service on the telephone with the  
3 physician or dentist who will be responsible for determining authorization of the health care  
4 service under review.

5 **26.1-36.12-05. Personnel qualified to review appeals.**

- 6 1. A prior authorization review organization shall ensure all appeals are reviewed by a  
7 physician or dentist. The reviewing individual:
- 8 a. Shall possess a valid nonrestricted license to practice medicine or dentistry;
  - 9 b. Must be in active practice in the same or similar specialty as the physician or  
10 dentist who typically manages the medical condition or disease for at least five  
11 consecutive years;
  - 12 c. Must be knowledgeable of, and have experience providing, the health care  
13 services under appeal;
  - 14 d. May not be employed by a prior authorization review organization or be under  
15 contract with a prior authorization review organization other than to participate in  
16 one or more of the prior authorization review organization's health care provider  
17 networks or to perform reviews of appeals, or otherwise have any financial  
18 interest in the outcome of the appeal;
  - 19 e. May not have been directly involved in making the adverse determination; and
  - 20 f. Shall consider all known clinical aspects of the health care service under review,  
21 including a review of all pertinent medical records provided to the prior  
22 authorization review organization by the enrollee's health care provider, any  
23 relevant records provided to the prior authorization review organization by a  
24 health care facility, and any medical literature provided to the prior authorization  
25 review organization by the health care provider.
- 26 2. A review of an adverse determination involving a prescription drug must be conducted  
27 by a licensed pharmacist or physician who is competent to evaluate the specific  
28 clinical issues presented in the review.

29 **26.1-36.12-06. Prior authorization - Nonurgent circumstances.**

- 30 1. If a prior authorization review organization requires prior authorization of a health care  
31 service, the prior authorization review organization shall make a prior authorization or

1 adverse determination and notify the enrollee and the enrollee's health care provider  
2 of the decision within two business days of obtaining all necessary information to  
3 make the decision. For purposes of this subsection, "necessary information" includes  
4 the results of any face-to-face clinical evaluation or second opinion that may be  
5 required.

6 2. A prior authorization review organization shall allow an enrollee and the enrollee's  
7 health care provider fourteen business days following a nonurgent circumstance or  
8 provision of health care services for the enrollee or health care provider to notify the  
9 prior authorization review organization of the nonurgent circumstance or provision of  
10 health care services.

11 **26.1-36.12-07. Prior authorization - Urgent health care services.**

12 A prior authorization review organization shall render a prior authorization or adverse  
13 determination concerning urgent health care services and notify the enrollee and the enrollee's  
14 health care provider of that prior authorization or adverse determination within twenty-four hours  
15 after receiving all information needed to complete the review of the requested health care  
16 services.

17 **26.1-36.12-08. Prior authorization - Emergency medical condition.**

18 1. A prior authorization review organization may not require prior authorization for  
19 prehospital transportation or for the provision of emergency health care services for an  
20 emergency medical condition.

21 2. A prior authorization review organization shall allow an enrollee and the enrollee's  
22 health care provider a minimum of two business days following an emergency  
23 admission or provision of emergency health care services for an emergency medical  
24 condition for the enrollee or health care provider to notify the prior authorization review  
25 organization of the admission or provision of health care services.

26 3. A prior authorization review organization shall cover emergency health care services  
27 for an emergency medical condition necessary to screen and stabilize an enrollee. If,  
28 within seventy-two hours of an enrollee's admission, a health care provider certifies in  
29 writing to a prior authorization review organization that the enrollee's condition  
30 required emergency health care services for an emergency medical condition, that  
31 certification will create a presumption the emergency health care services for the

1           emergency medical condition were medically necessary. The presumption may be  
2           rebutted only if the prior authorization review organization can establish, with clear and  
3           convincing evidence, that the emergency health care services for the emergency  
4           medical condition were not medically necessary.

5           4. The medical necessity or appropriateness of emergency health care services for an  
6           emergency medical condition may not be based on whether those services were  
7           provided by participating or nonparticipating providers. Restrictions on coverage of  
8           emergency health care services for an emergency medical condition provided by  
9           nonparticipating providers may not be greater than restrictions that apply when those  
10           services are provided by participating providers.

11           5. If an enrollee receives an emergency health care service that requires immediate  
12           post-evaluation or post-stabilization services, a prior authorization review organization  
13           shall make an authorization determination within two business days of receiving a  
14           request. If the authorization determination is not made within two business days, the  
15           services must be deemed approved.

16           **26.1-36.12-09. No prior authorization for medication assisted treatment.**

17           A prior authorization review organization may not require prior authorization for the  
18           provision of medication assisted treatment for the treatment of opioid use disorder.

19           **26.1-36.12-10. Retrospective denial.**

20           A prior authorization review organization may not revoke, limit, condition, or restrict a prior  
21           authorization if care is provided within forty-five business days from the date the health care  
22           provider received the prior authorization.

23           **26.1-36.12-11. Length of prior authorization.**

24           A prior authorization is valid for six months after the date the health care provider receives  
25           the prior authorization.

26           **26.1-36.12-12. Chronic or long-term care conditions.**

27           If a prior authorization review organization requires a prior authorization for a health care  
28           service for the treatment of a chronic or long-term care condition, the prior authorization  
29           remains valid for twelve months.

1       **26.1-36.12-13. Continuity of care for enrollees.**

2       1. On receipt of information documenting a prior authorization from the enrollee or from  
3       the enrollee's health care provider, a prior authorization review organization shall  
4       honor a prior authorization granted to an enrollee from a previous prior authorization  
5       review organization for at least the initial sixty days of an enrollee's coverage under a  
6       new policy.

7       2. During the time period described in subsection 1, a prior authorization review  
8       organization may perform its review to grant a prior authorization.

9       3. If there is a change in coverage of, or approval criteria for, a previously authorized  
10      health care service, the change in coverage or approval criteria does not affect an  
11      enrollee who received prior authorization before the effective date of the change for  
12      the remainder of the enrollee's plan year.

13      4. A prior authorization review organization shall continue to honor a prior authorization  
14      the organization has granted to an enrollee if the enrollee changes products under the  
15      same health insurance company.

16      **26.1-36.12-14. Failure to comply - Services deemed authorized.**

17      If a prior authorization review organization fails to comply with the deadlines and other  
18      requirements in this chapter, any health care services subject to review automatically are  
19      deemed authorized by the prior authorization review organization.

20      **26.1-36.12-15. Procedures for appeals of adverse determinations.**

21      1. A prior authorization review organization shall have written procedures for appeals of  
22      adverse determinations. The right to appeal must be available to the enrollee and the  
23      attending health care professional.

24      2. The enrollee may review the information relied on in the course of the appeal, present  
25      evidence and testimony as part of the appeals process, and receive continued  
26      coverage pending the outcome of the appeals process.

27      **26.1-36.12-16. Effect of change in prior authorization clinical criteria.**

28      If, during a plan year, a prior authorization review organization changes coverage terms for  
29      a health care service or the clinical criteria used to conduct prior authorizations for a health care  
30      service, the change in coverage terms or in clinical criteria does not apply until the next plan



1 year for any enrollee who received prior authorization for a health care service using the  
2 coverage terms or clinical criteria in effect before the effective date of the change.

3 **26.1-36.12-17. Notification to claims administrator.**

4 If the prior authorization review organization and the claims administrator are separate  
5 entities, the prior authorization review organization shall notify, either electronically or in writing,  
6 the appropriate claims administrator for the health benefit plan of any adverse determination  
7 that is reversed on appeal.

8 **26.1-36.12-18. Annual report to insurance commissioner.**

9 1. A prior authorization review organization shall report to the insurance commissioner by  
10 September first of each year, in a form and manner specified by the commissioner,  
11 information regarding prior authorization requests for the previous calendar year.

12 2. The report must include the:

13 a. Total number of prior authorization requests received;

14 b. Number of prior authorization requests for which an authorization was issued;

15 c. Number of prior authorization requests for which an adverse determination was  
16 issued;

17 d. Number of adverse determinations reversed on appeal; and

18 e. Reasons an adverse determination was issued, expressed as a percentage of all  
19 adverse determinations. The reasons may include:

20 (1) The patient did not meet prior authorization criteria;

21 (2) Incomplete information was submitted by the provider to the prior  
22 authorization review organization;

23 (3) The treatment program changed; or

24 (4) The patient is no longer covered by the health benefit plan.