MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2302

2001 SENATE HUMAN SERVICES

SB 2302

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2302

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 29, 2001

Tape Number	Side A	Side B	Meter #
2	X		30.2
2		X	3.5
February 5, 2001 2	X		7.8
Committee Clerk Signature	Carol Kolodjeski		

Minutes:

The hearing on SB 2302 was opened.

SENATOR ESPEGARD introduced the bill.

SUSAN ANDERSON, Insurance Dept, explained the bill. (Written testimony)

BRUCE LEVI, ND Medical Association, supports bill, (Written testimony)

ARNOLD THOMAS, Pres, ND Health Care Association, supports bill. We believe it will establish policies governing all three types of reviews which are currently in place in the hospitals. It is not our intent to put a burden on the insurance community.

Opposition:

DAN ULMER, BCSC, opposes bill. URAC often does retrospective. We are willing to change our opposition. Prospective review is getting qualification before procedure is done. Concurrent review as the procedure is going along. Retrospective review is being done and we don't think it is necessary to put it into statute. Would like time to bring back amendment.

SENATOR LEE: We are talking about those that fall through the cracks. MR. ULMER: Yes, those that fall out are usually coding issues. The claims representative looks at those. If there is a question they are looked at by a nurse. A nurse cannot deny; they can decide to pay. Only a physician in a qualified position can deny claims. SENATOR KILZER: What is URAC? I think retrospect review if definitely part of the review process.

BRENDA BLAZER, Health Insurance Association of America, opposes bill. (Written testimony)

The hearing was closed on SB2302.

Discussion was opened on 2302. SUSAN ANDERSON, Insurance Department, explained the amendments. SENATOR MATHERN moved the amendments. SENATOR ERBELE seconded the motion. Roll call vote carried 6-0. SENATOR KILZER moved DO PASS AS AMENDED. SENATOR FISCHER seconded the motion. Roll call vote carried 6-0. SENATOR KILZER will carry the bill on the Senate floor.

Prepared by the North Dakota
Insurance Department
February 5, 2001

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 "definition of" with "retrospective reviews as part of"

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

Page 1, replace lines 6 through 10 with the following:

"**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. "Retrospective" means utilization review of medical necessity that 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."

~~7.~~ 8. "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.

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

1. An agency of the federal government; or

2. 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."

Page 1, after line 10, insert the following:

"**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 in which to notify the provider of record, enrollee, or appropriate individual once in receipt of all information necessary to complete the review.

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

CONT

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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 shall 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

18327.0101
Title.0200

Adopted by the Human Services Committee
February 5, 2001

2-6-1
1012

PROPOSED AMENDMENTS TO SENATE BILL NO. 2302

Amendments to SB 2302 HS 2/6/1

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. "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. "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.

~~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:

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Renumber accordingly

Date: 02/5/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2302

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Amendments

Motion Made By Sen Mathern Seconded By Sen Erbele

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Ins. Dept amendment

Date: 2/5/01

Roll Call Vote #: 2

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2302

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do pass as amended

Motion Made By Sen Kilzer Seconded By Sen Fischer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Kilzer

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2302: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2302 was placed on the Sixth order on the calendar.

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"

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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>

8. "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.

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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.

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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 p[illegible] an expedited appeals process for emergency or life-[illegible] situations. Utilization review agents shall complete the [illegible] on of expedited appeals within forty-eight hours of the date t[illegible] eal 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:

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Renumber accordingly

2001 HOUSE HUMAN SERVICES

SB 2302

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2302

House Human Services Committee

❑ Conference Committee

Hearing Date February 20, 2001

Tape Number	Side A	Side B	Meter #
Tape 2	X		Tape didn't work
Committee Clerk Signature	Connie Easton		

Minutes:

Chairman Price, Vice Chairman Devlin, Rep. Dosch, Rep. Galvin, Rep. Klein, Rep. Pollert, Rep. Porter, Rep. Tieman, Rep. Weiler, Rep. Weisz, Rep. Cleary, Rep. Metcalf, Rep. Niemeier, Rep. Sandvig

Chairman Price: Opened hearing on SB 2302.

Susan Anderson: Legal Counsel for the North Dakota Insurance Department. (See written testimony.) The utilization review chapter, N.D. Cent. Code Chapter 26.1-26.4, establishes guidelines on the timeliness and professional qualifications for people who make decisions as to whether a procedure is medically necessary. The current law places restrictions on reviews that are done before a procedure occurs (prospectively) or during a procedure (currently). Such restrictions require that physicians determine the necessity or appropriateness of the procedure, notification of appeal rights, and restrictions on the timeliness of the decision. The department believes that restrictions should apply whether a procedure is being reviewed prospectively,

concurrently, or retrospectively (after the procedure has occurred). The department, Medical Association, and BCBS worked together in the Senate to amend SB 2302 to provide restrictions for retrospective utilization review. These restrictions require that utilization review agents notify the doctor, enrollee, or other appropriate individual of its initial determination within five business days of receipt of the appropriate information. Subsequent determinations must be completed no later than 30 days after receipt of the required information. As the committee can see, different time restrictions apply to prospective or concurrent reviews than retrospective reviews. The difference in the time restrictions is due to the nature of retrospective reviews. In retrospective reviews, the procedure has been completed and the urgency for decision making is not as pressing in comparison to prospective or concurrent review where the individual could be awaiting a procedure. The health insurers association will point out that this law was originally passed as a managed care bill to provide cost containment for health insurers. The department agrees with this concept but would like to point out that some carriers do very little prospective or concurrent review and wait to review the medical necessity of a procedure once a claim has been filed. Some carriers are using nurses to provide this retrospective review. If such a review had occurred prospectively or concurrently, a physician would have had to review that procedure. Whether the review is done on a prospective, concurrent, or retrospective basis, the department believes that qualified individuals should be making medical decisions. In modifying the definition of utilization review it would require those individuals making medical decisions to be qualified to make those decisions. We would urge a DO PASS on SB 2302.

Dan Ulmer: Blue Cross/Blue Shield. ??????????????????

Chairman Price: The five days doesn't start until you've gotten what you've asked for?

Dan Ulmer: Correct.

Bruce Levi: North Dakota Medical Association. (See written testimony.) The North Dakota Medical Association supports Engrossed SB 2302. Engrossed SB 2302 would ensure that the important, minimum standards for utilization review in North Dakota law apply to retrospective review of medical necessity and the appropriate use of health care resources and services. In other words, the standards would apply to utilization review that an insurer would conduct after services have been provided to a patient - typically, an appeals procedure that applies if the insurer denies coverage for medical services. The clarification envisioned by SB 2302 is very minimal, as are the standards in place in North Dakota under Section 26.1-26.4-04. Most states - at least 33 to date - have taken this issue much further in requiring some form of external review by an independent reviewer.

Chairman Price: Close hearing on SB 2302.

COMMITTEE WORK:

REP. CLEARY: Move a DO PASS.

REP. NIEMEIER: Second.

13 YES 0 NO 1 ABSENT CARRIED BY REP. METCALF

Date: 2-20-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2302

House Human Services Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By Rep. Cleary Seconded By Rep. Niemeier

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert	✓				
Todd Porter					
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 13 No _____

Absent 1

Floor Assignment Rep. Metcalf

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2302, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2302 was placed on the Fourteenth order on the calendar.

2001 TESTIMONY

SB 2302

Bruce Levi
ND Medical Association

Testimony in Support of SB 2302
Senate Human Services Committee
January 29, 2001

The North Dakota Medical Association supports SB 2302.

SB 2302 would ensure that the important, minimum standards for utilization review in North Dakota law apply to *retrospective review* of medical necessity and the appropriate use of health care resources and services. In other words, the standards would apply to utilization review that an insurer would conduct after services have been provided to a patient – typically, an appeals procedure that applies if the insurer denies coverage for medical services. In North Dakota these minimum standards are provided in NDCC Section 26.1-26.4-04 (attached), which include the following requirements:

- Minimum notification periods
- Initial reviews must be made by a physician or, if appropriate, a licensed psychologist (or in accordance with standards or guidelines approved by a physician or licensed psychologist)
- An adverse determination must state reasons and provide information on how to appeal
- Appeal procedures must be in place that require all appeal decisions to be made by a physician or, if appropriate, a licensed psychologist and that all appeals be made within thirty days
- The availability of toll-free telephone forty hours per week
- Assurances that appeals procedures are consistent with confidentiality laws
- A requirement for review by a physician trained in the relevant specialty for any final determination regarding medical necessity
- Utilization review determinations must be made by physicians and psychologists licensed in North Dakota

These are not burdensome standards. Instead, the standards are consistent with basic notions of fairness in ensuring that medical care is not inappropriately denied or reduced through any utilization review program. The Association proposed a similar revision of the definition of

"utilization review" in SB 2400 in 1999, and advocated expansion and clarification of the minimum standards. SB 2302 would clarify an important issue – do the current utilization review standards apply to appeals of denials for coverage that occur after services have been provided to a patient?

According to the ND Insurance Department, the vast majority of states apply their utilization review statutes to "retrospective" review. This is also the approach taken in the NAIC (National Association of Insurance Commissioners) Model Act. That Act further defines "retrospective review" to mean "utilization review of medical necessity that 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 of payment."

The clarification envisioned by SB 2302 is very minimal, as are the standards in place in North Dakota under Section 26.1-26.4-04. Most states – at least 33 to date – have taken this issue much farther in requiring some form of external review by an independent reviewer.

The North Dakota Medical Association urges a DO PASS on SB 2302.

(Effective August 1, 2000) 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 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.

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 principal reason for the determination and the procedures to initiate an appeal of the determination.

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 no later than thirty days from the date the appeal is filed and the receipt of all information necessary to complete the appeal.

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.

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.

However, 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.

Source: S.L. 1991, ch. 316, § 4; 1993, ch. 305, § 3; 1999, ch. 257, § 4; 1999, ch. 264, § 2.

Brenda L. Blazer
Health Insurance Association of America

TESTIMONY ON SENATE BILL 2302
Senate Human Services Committee
January 29, 2001

The Health Insurance Association of America (HIAA) is an insurance trade association representing insurance companies that write accident and health insurance on a nationwide basis. The HIAA and its members support the present status of the law regarding utilization review on a concurrent and prospective basis. The HIAA strongly opposes SB 2302 purporting to add "retrospective" review of utilization.

Utilization review is the assessment of treatment in accordance with established guidelines and standards before and during the delivery of health care. The purpose of utilization review is to enhance the quality, appropriateness, medical necessity, and cost-effectiveness of health care. The review of care already given is claims review geared toward determinations of coverage and payment not utilization. Utilization review has been instrumental in controlling health care costs.

Retrospective utilization review arises from confusion about "medical necessity" as a boundary of health coverage and "medical necessity" as a clinical determination by a treating health care provider. Retrospective utilization review removes the ability of the health plan to determine the scope of coverage under the insurance contract.

The Health Care Service Utilization Review chapter of the North Dakota Century Code is geared toward speedy decisions with respect to recommended or ongoing

treatment. For example, notification of a determination by a utilization review agent must be communicated within two business days of the receipt of the request for determination and receipt of all information necessary to complete the review. Review of care already given hardly merits a two-day review requirement.

SB 2302 attempts to equate utilization review approval to authorization for claim payments. Denial of payment of a claim is subject to health plan review procedures and state regulation. If SB 2302 is passed each denial of payment of a claim would be subject to physician review. Such a requirement would substantially increase the cost of claims processing.

The percentage of North Dakota citizens insured with an out-of-state health insurance carrier decreases yearly. Testimony in this legislative session estimates that only 15 to 20 percent of our citizens are insured with an out-of-state carrier. The increased cost of doing business in North Dakota is not an incentive to insurance companies to enter or stay in North Dakota.

We respectfully request the committee reject the concept of "retrospective" utilization review as set forth in SB 2302.

SENATE BILL NO. 2302

Presented by: **Susan J. Anderson**
Legal Counsel
North Dakota Insurance Department

Before: **Human Services Committee**
Senator Judy Lee, Chairman

Date: **January 29, 2001**

TESTIMONY

Madam Chair and members of the committee:

Good Morning, Madam Chair and members of the Senate Human Services Committee. My name is Susan Anderson and I am Legal Counsel for the North Dakota Insurance Department. I am here today to testify in support of SB 2302.

The utilization review chapter, N.D. Cent. Code Chapter 26.1-26.4, establishes guidelines on the timeliness and professional qualifications for people who make decisions as to whether a procedure is medically necessary. The current law places restrictions on reviews that are done before a procedure occurs (prospectively) or during a procedure (currently). Such restrictions require that physicians determine the necessity or appropriateness of the procedure, notification of appeal rights, and restrictions on the timeliness of the decision. The Department believes that the same restrictions should apply whether a procedure is being reviewed prospectively, concurrently, or retrospectively (after the procedure has occurred).

The health insurers association will point out that this law was originally passed as a managed care bill to provide cost containment for health insurers. The Department agrees with this concept but would like to point out that some carriers do very little prospective or concurrent review and wait to review the medical necessity of a procedure once a claim has been filed. Some carriers are using nurses to provide this retrospective review. If

such a review had occurred prospectively or concurrently, a physician would have had to review that procedure. Whether the review is done on a prospective, concurrent, or retrospective basis, the Department believes that qualified individuals should be making medical decisions. In modifying the definition of utilization review it would require those individuals making medical decisions to be qualified to make those decisions.

We would urge a "do pass" on SB 2302.

SENATE BILL NO. 2302

Presented by: **Susan J. Anderson**
Legal Counsel
North Dakota Insurance Department

Before: **Human Services Committee**
Representative Clara Sue Price, Chairman

Date: **February 20, 2001**

TESTIMONY

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The utilization review chapter, N.D. Cent. Code Chapter 26.1-26.4, establishes guidelines on the timeliness and professional qualifications for people who make decisions as to whether a procedure is medically necessary. The current law places restrictions on reviews that are done before a procedure occurs (prospectively) or during a procedure (currently). Such restrictions require that physicians determine the necessity or appropriateness of the procedure, notification of appeal rights, and restrictions on the timeliness of the decision. The Department believes that restrictions should apply whether a procedure is being reviewed prospectively, concurrently, or retrospectively (after the procedure has occurred).

The Department, Medical Association, and Blue Cross Blue Shield worked together in the Senate to amend Senate Bill No. 2302 to provide restrictions for retrospective utilization review. These restrictions require that utilization review agents notify the doctor, enrollee, or other appropriate individual of its initial determination within five business days of receipt of the appropriate information. Subsequent determinations must be completed no later

than 30 days after receipt of the required information. As the committee can see, different time restrictions apply to prospective or concurrent reviews than retrospective reviews. The difference in the time restrictions is due to the nature of retrospective reviews. In retrospective reviews, the procedure has been completed and the urgency for decisionmaking is not as pressing in comparison to prospective or concurrent review where the individual could be awaiting a procedure.

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We would urge a "do pass" on SB 2302.

Bruce Levi
ND Medical Association

Testimony in Support of Engrossed SB 2302
House Human Services Committee
February 20, 2001

The North Dakota Medical Association supports Engrossed SB 2302.

Engrossed SB 2302 would ensure that the important, minimum standards for utilization review in North Dakota law apply to *retrospective review* of medical necessity and the appropriate use of health care resources and services. In other words, the standards would apply to utilization review that an insurer would conduct after services have been provided to a patient – typically, an appeals procedure that applies if the insurer denies coverage for medical services. In North Dakota these minimum standards are provided in NDCC Section 26.1-26.4-04 which include the following requirements:

- Minimum notification periods, revised under Engrossed SB 2302 to give the insurer five business days to notify the provider of an initial determination under retrospective review (NDCC 26.1-26.4-04(1))
- Determinations as to necessity or appropriateness of an admission, service, or procedure must be made by a physician or, if appropriate, a licensed psychologist (or in accordance with standards or guidelines approved by a physician or licensed psychologist) (26.1-26.4-04(2))
- An adverse determination must state reasons and provide information on how to appeal (26.1-26.4-04(3))
- Appeal procedures must be in place that require all appeal decisions to be made by a physician or, if appropriate, a licensed psychologist and that all appeals be made within thirty days. As revised under Engrossed SB 2302, provisions relating to expedited appeals would not apply to retrospective reviews. (26.1-26.4-04(4)
- The availability of toll-free telephone forty hours per week and returned calls (26.1-26.4-04(5) and (6))
- Assurances that appeals procedures are consistent with confidentiality laws (26.1-26.4-04(7)

- Utilization review determinations must be made by physicians and psychologists licensed in North Dakota (26.1-26.4-04(8))
- Assurances that coverage for emergency services under prudent layperson standard will not be denied on a retrospective basis (26.1-26.4-04(9))
- As revised under Engrossed SB 2302, subsequent appeals of retrospective decisions must be completed within thirty days from the date the appeal is filed and all information is received (26.1-26.4-04(10))

These are not burdensome standards. Instead, the standards are consistent with basic notions of fairness in ensuring that medical care is not inappropriately denied or reduced through any utilization review program. Engrossed SB 2302 would clarify an important issue – do the current utilization review standards apply to appeals of denials for coverage that occur after services have been provided to a patient? The answer is "yes," with revisions as made by the Senate.

According to the ND Insurance Department, the vast majority of states apply their utilization review statutes to "retrospective" review. This is also the approach taken in the NAIC (National Association of Insurance Commissioners) Model Act. The new definition of "retrospective review" in the bill is the NAIC definition that the Association suggested in the Senate.

The clarification envisioned by SB 2302 is very minimal, as are the standards in place in North Dakota under Section 26.1-26.4-04. Most states – at least 33 to date – have taken this issue much farther in requiring some form of external review by an independent reviewer.

The North Dakota Medical Association urges a DO PASS on Engrossed SB 2302.