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Deanna Wallwitt 5/17/03
Operator's Signature Date

2003 SENATE HUMAN SERVICES

SB 2184

2003 SENATE STANDING COMMITTEE MINUTES
BILL/RESOLUTION NO. SB 2184

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 20, 2003

Tape Number	Side A	Side B	Meter #
2	X		1054 - end
3	X		0 - 1525
Committee Clerk Signature	Donna Kramer		

Minutes:

SENATOR JUDY LEE opened the public hearing for Senate Bill 2184 relating to minimum standards for utilization review agents.

SENATOR BROWN introduced the bill.

DAN ULMER, lobbyist for Blue Cross Blue Shield, testified. (Meter # 1100 - 1320)

An issue was discovered with one of the rules that the Department of Labor had issued regarding utilization review. It required 72 hours to essentially decide an urgent case. Under state law, we had 48 hours. It has been a statute since 1991. We hired Chris Edison, Attorney, who created a text for us. We met with the Hospital Association, Medical Association and Insurance Department and came up with the bill before you.

CHRIS EDISON, Attorney in private practice and involved with BCBS, testified.

(Copy of Overview for Dept. of Labor Claim and Appeal Requirements attached) (Meter # 1316 - 1911) Make the time frames as specified by the Dept. of Labor standard in North Dakota.

SENATOR LEE: What is the pre-service now?

CHRIS EDISON: The state statute lays out two standards. Two business days - pre-service claims, 5 - 30 days - retrospective claims. Discussion on difference between federal and state laws. (Meter #1951 - 3163)

ROD ST. AUBYN, of BCBS, responded regarding emergency and urgent care as being the question. If a physician determines it is urgent care, we are obligated. Prior approval can be done. If it is an emergency, this does not apply. (Meter #3203 - 3413

SENATOR POLOVITZ: Change of length of time is not going to affect the patient?

ROD ST. AUBYN: Affects the time frames within a patient will get notification of whether or not a particular service is covered. (Meter # 3485)

SENATOR LEE: Question on long-term care and hospice discharge? What services will it affect? How does this really affect the patient? Answers and Discussion (Meter #3492 - 3785)

CHRIS EDISON: I can provide a list of examples that can provide a concrete way in which you can see how North Dakota law would be changed, what the time frames would be, how they would be applicable, and if they lengthened - how much they're lengthened in a given situation. And if they're shortened, how much.

SENATOR LEE: And equally important what is not affected as far as the patient services.

ROD ST. AUBYN: Problem of definition of emergency and urgent. (Meter # 3892 - 3962)

SENATOR LEE: Clarification of urgent or emergency. (Meter #3967 - 4135)

SENATOR BROWN: Five - 15 days when we are talking about a preservice claim?

CHRIS EDISON: Maximum 15 days. (Meter #4235 - 4516)

SENATOR LEE: Has it been a struggle for providers to do the study in the time frame now?

DAN ULMER: (Meter #4554 - 4683) Probably not.

SENATOR BROWN: Gave an example of his wife going through cancer treatment.

SENATOR POLOVITZ: How does this affect the payments? Does that give the whoever reviews the health problem more ability to see what they don't have to pay for? (Meter #4904)

CHRIS EDISON: This does not change the reimbursement system. (Meter # 4933 - 5088)

ROD ST. AUBYN: No difference as far as payment in the time frame change. (Meter # 5089 - 5609)

BRUCE LEVI, with the North Dakota Medical Association, testified in a neutral category. There are concerns about present language of the bill. Proposed amendment passed out. (Attachment enclosed) This an issue that the medical community has some great concern about. And what constitutes an emergency? (Meter # 6101 to end of Tape 2, Side A) (Continued Tape 3, Side A, 0 - 240) There is a provision for independent review.

JOHN KAPSNER, in behalf of the North Dakota Hospital Association, testified. They support amendments of the North Dakota Medical Association. In dealing with a federal rule, the best way to deal with this is to allow the commissioner of Insurance the discretion to adopt rules through which would be in compliance with the Federal Dept. of Labor regulations. Several questions of preemption. Suggestion of Insurance Department conducting public hearings. (Meter # 258 - 587)

VANCE MAGNUSON, of the ND Insurance Department, testified in a neutral position. He stated what this bill was amending was pertaining to utilization review. So, the time frames as far as claim payments - North Dakota still has more stringent claim period standards for payment of claims than in federal standards. Supportive of amendment as proposed by Mr. Levi except

for the lead-in paragraph. This conflicts with our claim payment time period. (Meter #606 - 846)

SENATOR LEE: Asked if the Insurance Dept. would provide an additional amendments for us to consider.

VANCE MAGNUSON: Yes.

CHRIS EDISON: Talked about the issue in shortening up the time frames. (Meter # 888 - 1084)

DAN ULMER: The goal here is trying to come up with a consistent utilization review process. (Meter # 1134 - 1205)

SENATOR BROWN: Your amendment really is changing utilization review to timely adjudication of payment of claim. Isn't that a separate issue?

BRUCE LEVI: Response regarding "clean claim." (Meter # 1230 - 1460)

DAN ULMER: The last piece of amendment is a whole new issue.

SENATOR LEE: It would appropriate if we get into that subject to make sure that other people who are interested parties to have a chance to come and talk about that as well.

The Public Hearing on SB 2184 was closed.

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2184

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 22, 2003

Tape Number	Side A	Side B	Meter #
2	X		1400 - 1940
Committee Clerk Signature			

Minutes:

SENATOR JUDY LEE reopened the discussion on SB 2184 relating to minimum standards for utilization review agents. The proposed amendments that were brought in by the Insurance Department were mentioned.

Discussion. It was proposed that the amendments be disregarded.

SENATOR BROWN made a motion to do pass.

SENATOR FISCHER seconded the motion.

Discussion.

Roll Call was read. 6 yes 0 no.

SENATOR BROWN will be the carrier.

Date: 01-22-03
Roll Call Vote #: (1)

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2184

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken "Do Pass"

Motion Made By Sen. Brown Seconded By Sen. Fischer

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman	✓				
Senator Richard Brown - V. Chair.	✓				
Senator Robert S. Erbele	✓				
Senator Tom Fischer	✓				
Senator April Fairfield	✓				
Senator Michael Polovitz	✓				

Total (Yes) 6 No 0

Absent _____

Floor Assignment Sen. Brown.

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

REPORT OF STANDING COMMITTEE (410)
January 22, 2003 2:08 p.m.

Module No: SR-12-0936
Carrier: Brown
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2184: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2184 was placed on the Eleventh order on the calendar.

2003 HOUSE HUMAN SERVICES

SB 2184

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2184

House Human Services Committee

❑ Conference Committee

Hearing Date March 5, 2003

Tape Number	Side A	Side B	Meter #
1	x		42.6 - 61.6
		x	0.0 - 21.0
2	x		44.0 - 47.7
Committee Clerk Signature	Sharon Lanfear		

Minutes:

Dan Ulmer of Blue Cross/Blue Shield of ND appeared in support with written testimony.

Chris Edison, Legal Counsel for BC/BS appeared in support with written explanation/overview. There is a system of dual regulation, states can regulate those employer sponsor health plans which are done through insurance. This other area is not regulated by the States and BC/BS and other carriers are involved in both of those systems. We have in ND adopted standards for utilization review and basically what that means is any time a health insurer is looking at a particular service that one of their enrollees is going to have done by a physician and they are determining whether it is medically necessary or appropriate as a cost to _____. What this bill is intended to do is actually 2 fold. SB 2184 seeks to make one set of standards that govern the fully insured market place, the self insured market place and it actually seeks to give the insurance dept. regulatory authority over the standards that are going to be applicable to the fully insured market place. It simply adopts the federal rule by rep. What the federal specifically does

is say, here is what you have to do, provide notification and make determinations of at a

maximum.

Rep Amerman: Who do they appeal to? who hears the appeals?

Answer; That would be left up to the carrier what will make up their appeals committee.

Rep. Niemeier: expedited appeals process, they moved from 2 days to 3 days, an emergency & life threatening situations will be considered, how is that determination made?

Answer: If the physician says it is.

Rep. Potter: Why has it gone from 2 to 15 days, that seems quite a difference.

Answer: Its because that's what the federal law requires, they want to have 1 set of standards.

Mr. Ulmer: We are trying to come up with one process.

Rep. Price: For example, if somebody had State Farm Ins. and that's a carrier from out of state, so it would be much easier for those insurance companies and assuming if we were on the DOL laws.

Answer: They would like to see/have DOL standards be adopted by every state, so that they have one set of standards that they have to comply with and don't have to have another overlay where they make a determination, okay we're in ND now, what are their standards.

Rep. Amerman: Is this a cost savings if we pass this bill?

Answer by Rod St. Aubyn: It will cost more if this bill doesn't pass.

Dave Peske, ND Medical Association appeared opposition of mass adoption of this bill. Mainly this is a patient protection issue, and doesn't think that a physician will be involved in what rules apply to what plan.

John Kaspner, attorney with ND with the ND Hospital Assoc., stating he was involved with the initial drafting of all the proposals early on. I'm simply here to state that we too agree on this issue with the ND Medical Assoc. and feel the better approach to this issue is to allow _____ rules in the insurance dept.

Closed hearing.

Rep. Porter made a motion for DO PASS, second by Rep. Kreidt

Rep. Price: This is the Dept. of Labor making all policies in the State go by the same.

VOTE: 11 - 0 - 2 Rep. Niemeier will carry the bill.

Date: March 5, 2003
Roll Call Vote #:

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2184

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Rep Porter Seconded By Rep Kreidt

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair A			Rep. Bill Amerman	✓	
Rep. Robin Weisz A			Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 11 No 0

Absent 2

Floor Assignment Rep. Niemeier

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

REPORT OF STANDING COMMITTEE (410)
March 6, 2003 10:27 a.m.

Module No: HR-40-4073
Carrier: Niemeier
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2184: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** (11 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). SB 2184 was placed on the Fourteenth order on the calendar.

(2) DESK, (3) COMM

HR-40-4073

2003 TESTIMONY

SB 2184

OVERVIEW OF 29 CFR § 2560.503-1
(DEPARTMENT OF LABOR CLAIM AND APPEAL REQUIREMENTS)

Presented by:

Chris Edison
Registered Lobbyist No. 303
Representing Blue Cross Blue Shield of North Dakota

1. General Requirements for Claim Procedures. Employee benefit plans must maintain reasonable claim procedures. The procedures will be determined "reasonable" only if:

   A. A description of the claim procedures and applicable time frames is included in summary plan description;

   B. The procedures do not contain any provision that unduly inhibits the initiation or processing of a claim;

   C. The procedures do not preclude an authorized representative from acting on behalf of a claimant in pursuing a claim or an appeal; (However, the plan may establish reasonable procedures for determining whether a person is authorized to act on behalf of a claimant);

   D. The procedures contain processes and safeguards to ensure and verify claim determinations are made in accordance with plan documents and are that plan provisions are applied consistently; and

   E. The claims procedures comply with the requirements of the rule regarding applicable time frames and the content of notifications of adverse determinations.

2. Time Frames for Claim Determinations. Every group health plan must make a determination regarding a claim for benefits as follows:

   A. Claims involving urgent care:

      (1) "Claims involving urgent care" means "any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

         a. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

         b. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim."

(2) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" must be treated as such.

(3) The plan must notify the claimant of its determination as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim.

B. Pre-service claims:

(1) "Pre-service claims" means "any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care."

(2) The plan must notify the claimant of its determination (whether adverse or not) within a reasonable period time appropriate to the medical circumstances, but not later than **15 days** after receipt of the claim.

(3) The plan may extend the initial time period once for up to **15 days** if the extension is necessary due to matters beyond the control of the plan.

C. Post-service claims:

(1) "Post-service claims" means "any claim for a benefit a under a group health plan that is not a pre-service claim."

(2) The plan must notify the claimant of an adverse determination within a reasonable period of time, but not later than **30 days** after receipt of the claim;

(3) The plan may extend the initial period once for up to **15 days** if the extension is necessary due to matters beyond the control of the plan.

3. Content of Claim Notification. Every group health plan must provide a claimant with a written or electronic notification of any adverse benefit determination which contains:

A. The reason(s) for adverse determinations;

B. The specific plan provisions on which the determination is based;

C. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the information is necessary;

D. A description of the plan's appeal procedures and the time frames applicable to those procedures;

E. Either a copy of any specific rule or guideline relied on by the plan in making the determination or a statement that the rule or guideline was used and will be provided free of charge;

F. If the adverse determination is based on medical necessity or other exclusion or limit involving medical judgment, either an explanation of the scientific or clinical judgment for the determination or a statement that the scientific or clinical judgement will be provided free of charge;

G. If the claim involved urgent care, a description of the plan's expedited appeal process.

4. Appeals from Adverse Determinations. Every plan must establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination and under which there will be a full and fair review of the claim and the adverse benefit determination. The appeal procedures for a group health plan will be deemed reasonable only if the procedures:

A. Provide the claimant to submit written comments, documents, records, and other information relating to the claim;

B. Provide the claimant access, upon request and free of charge, access to, and copies of, all relevant information to the claim;

C. Provide for a review that takes into account all comments, documents and other information submitted by the claimant relating to the claim;

D. Provide at least **180 days** following receipt of a notification of an adverse benefit determination in which to appeal;

E. Provide for a review that does not defer to the initial determination and is conducted by an individual who is neither the individual who made the initial determination nor that persons subordinate;

5. Time Frames Governing Appeals.

A. Urgent Care Claims. The plan must make a determination on review and notify the claimant as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the request for review.

B. Pre-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of the request for review.

C. Post-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time, but not later than **60 days** after receipt of the request for review.

6. Content of Appeal Notification. Every group health plan must provide a claimant with a written or electronic notification of its determination on appeal which contains:

A. The specific reason(s) for the adverse determination;

B. A reference to the specific plan provisions on which the benefit determination is based;

C. A statement that the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents and information relevant to the claim;

D. A statement describing any voluntary appeal procedures offered by the plan;

E. Either a copy of any specific rule or guideline relied on by the plan in making the determination or a statement that the rule or guideline was used and will be provided free of charge;

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G. If the claim involved urgent care, a description of the plan's expedited appeal process.

7. Preemption of State Law. The Department of Labor regulation does not preempt state law regulating insurance except to the extent the state law "prevents the application of a requirement of" the regulation.

OVERVIEW OF 29 CFR § 2560.503-1
(DEPARTMENT OF LABOR CLAIM AND APPEAL REQUIREMENTS)

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D. A description of the plan's appeal procedures and the time frames applicable to those procedures;

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4. Appeals from Adverse Determinations. Every plan must establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination and under which there will be a full and fair review of the claim and the adverse benefit determination. The appeal procedures for a group health plan will be deemed reasonable only if the procedures:

A. Provide the claimant to submit written comments, documents, records, and other information relating to the claim;

B. Provide the claimant access, upon request and free of charge, access to, and copies of, all relevant information to the claim;

C. Provide for a review that takes into account all comments, documents and other information submitted by the claimant relating to the claim;

D. Provide at least **180 days** following receipt of a notification of an adverse benefit determination in which to appeal;

E. Provide for a review that does not defer to the initial determination and is conducted by an individual who is neither the individual who made the initial determination nor that persons subordinate;

5. Time Frames Governing Appeals.

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B. Pre-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of the request for review.

C. Post-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time, but not later than **60 days** after receipt of the request for review.

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G. If the claim involved urgent care, a description of the plan's expedited appeal process.

7. Preemption of State Law. The Department of Labor regulation does not preempt state law regulating insurance except to the extent the state law "prevents the application of a requirement of" the regulation.

SB 2184 brings North Dakota utilization review statutes into line with the Department of Labor regulations that went into effect in July of 2002.

BCBSND has been accredited by URAC (utilization review accreditation committee, a nationally recognized accrediting body) since around 1990. In 1991 the present utilization review statutes were put in place and all fully insured health plans have used these statutes or URAC to assure that they were in compliance. It has been BCBSND's policy to review utilization for all of our plans, whether fully or self-insured, under the same accredited process.

However, self-funded ERISA plans are not only exempt from state regulation but, until the recent DOL regulations, enforcement could only be described as minimal.

When the DOL regulations came forth in 2002 all ERISA (self-insured and fully insured) plans were expected to meet the new UR standards. Thus insurers and providers find themselves having to meet two separate sets of standards based on whether or not the plan is fully (state law) or self-insured (federal ERISA).

The DOL standards do not preclude states from becoming stricter than federal law, however self-funded plans still don't have to meet state standards. Therefore we at BCBSND introduced SB2184 in order to impose one set of UR standards across all plans in North Dakota and for the first time North Dakota is being allowed an opportunity to regulate both the fully and self-insured market in the area of utilization review.

It is our position that providers, consumers, and insurers should only have to meet one set of UR standards and not have to worry about the technicalities of whether they working with a fully or self-insured product and SB2184 provides that opportunity.

Example-

Under North Dakota law a UR agent may not deny coverage or require prior authorization for emergency services. This will not change under SB2184.

Utilization review has three types reviews: prospective review (prior approval, prior to services being rendered), concurrent review (while services are being rendered), or retrospective review (after services have been rendered).

Under the DOL rules regarding prior approval for urgent care a decision for a request for services must be made within 72 hours. Under North Dakota law there is no mention of urgent care.

Under North Dakota law a request for prior approval services (see attached) must be rendered within 2 business days after receipt of all information necessary to complete the review.

Thus a difference in UR standards exists between fully insured (state regulated) and ERISA (federal) plans. This difference creates a scenario where different computer systems, different interpretations, and such lead to added costs and complications that don't need to exist between consumers, providers, insurers solely based on type of health plan. SB2184 would eliminate this difference.

This is but one example of the differences between the new DOL rules and current law. We urge your support.

Dan Ulmer

AVP Government Relations
BCBSND

SECTION 3
MANAGED BENEFITS

This section describes BCBSND's managed benefits programs and the Member's responsibilities under these programs. The Member's medical care is between the Member and the Member's Health Care Provider. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. BCBSND only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.**

The managed benefits provisions of this Benefit Plan provide that care must be provided or authorized by the SelectChoice Network chosen by the Subscriber. The SelectChoice Network assumes responsibility for the coordination of a Member's health care needs and that the health care system is properly accessed and utilized. However, if a Member seeks care on a Self-Referral basis without an Authorized Referral from the SelectChoice Network, compliance with the following Managed Benefits Provisions becomes the responsibility of the Member.

3.1 PRIOR APPROVAL PROCESS

This Benefit Plan requires Members to obtain Prior Approval before benefits are available for specified services, including:

A. assisted reproductive technology for GIFT, ZIFT, ICSI and IVF;
B. biofeedback services beyond the initial 4 sessions for each condition covered under this Benefit Plan;
C. chronic pain management program;
D. cosmetic surgeries;
E. dental anesthesia and hospitalization;
F. electric wheelchairs;
G. growth hormone therapy/treatment;
H. hearing aids for Members up to age 18;
I. human organ and tissue transplants, except kidney and cornea transplants;
J. human organ and tissue transplants second opinions, except kidney and cornea transplants;
K. insulin infusion pump;
L. morbid obesity surgery;
M. obstructive sleep apnea treatment;
N. orthodontic services for the treatment of temporomandibular or craniomandibular joint disorders;
O. osseointegrated implants;
P. out-of-country services - all elective admissions and services received outside the United States;
Q. penile prosthesis;
R. psychiatric or substance abuse Admissions out-of-state;
S. rhinoplasty;
T. sleep studies; and
U. weight loss Prescription Medications or Drugs.

To request Prior Approval, the Member or the Member's Health Care Provider, on the Member's behalf, must notify BCBSND of the Member's intent to receive services requiring Prior Approval. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary. This information must be submitted in writing from the Member's Health Care Provider.

Receipt of Prior Approval does not guarantee payment of benefits. All services provided are subject to further review by BCBSND to ensure the services are Medically Appropriate and Necessary. Benefits will be denied if the Member is not eligible for coverage under this Benefit Plan on the date services are provided or if services received are not Medically Appropriate and Necessary as determined by BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

Benefits will be denied if Prior Approval is not obtained prior to the receipt of services.

Information on the guidelines and criteria for Prior Approval are available from Participating Health Care Providers and BCBSND upon written request.

3.2 PREAUTHORIZATION

Preauthorization to BCBSND is required by each Member or the Member's representative prior to services being provided for the following services:

- Inpatient Admissions to a Health Care Provider not participating with BCBSND;
- Skilled Nursing Facility;
- Hospice;
- Home Health Care; and
- Psychiatric and Substance Abuse Admissions, including Ambulatory Behavioral Health Care (Partial Hospitalization) or Residential Treatment. All out-of-state Admissions require Prior Approval from BCBSND. See Section 3.1.

If the Member's medical condition does not allow the Member to obtain Preauthorization due to an emergency Admission, the Member or the Member's representative is requested to notify BCBSND of the Admission during the next BCBSND business day or as soon thereafter as reasonably possible to obtain authorization. The Preauthorization Sanction will not apply to Emergency Services.

Notification Responsibility

If a Member seeks Covered Services from a Health Care Provider that participates with BCBSND, the Participating Health Care Provider assumes responsibility for all Preauthorization requirements.

If a Member seeks Covered Services from a Health Care Provider that does not participate with BCBSND, compliance with Preauthorization requirements is the Member's responsibility.

BCBSND will issue a notice of authorization, partial authorization or denial of authorization following review of the Preauthorization request.

To inquire on the Preauthorization process, please contact Member Services at the telephone number and address on the back of the Identification Card.

Receipt of Preauthorization does not guarantee payment of benefits. All services provided are subject to further review by BCBSND to ensure the services are Medically Appropriate and Necessary. Benefits will be denied if the Member is not eligible for coverage under this Benefit Plan on the date services are provided or if services received are not Medically Appropriate and Necessary as determined by BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

If Preauthorization is not obtained in compliance with this provision, benefits will be denied or reduced as follows:

- the benefit reduction will not be applied to any Cost Sharing Amounts.
- after any Cost Sharing Amounts are applied, benefits will be reduced by an additional 20%.
- the total benefit reduction will be limited to $500 per Member per Admission.

3.3 CONCURRENT REVIEW

Concurrent review is the ongoing review of the Medical Appropriateness and Necessity of the required Admissions outlined in Section 3.2 to an Institutional Health Care Provider. BCBSND will monitor the inpatient Admission to determine whether benefits will be available for continued inpatient care.

If BCBSND determines benefits are not available because the continued stay is not Medically Appropriate and Necessary, BCBSND will provide notice to the Member, the Member's attending Professional Health Care Provider or the Institutional Health Care Provider. No benefits will be available for services received after the date provided in BCBSND's notice of the termination of benefits.

OVERVIEW OF 29 CFR § 2560.503-1
(DEPARTMENT OF LABOR CLAIM AND APPEAL REQUIREMENTS)

Presented by:

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1. General Requirements for Claim Procedures. Employee benefit plans must maintain reasonable claim procedures. The procedures will be determined "reasonable" only if:

   A. A description of the claim procedures and applicable time frames is included in summary plan description;

   B. The procedures do not contain any provision that unduly inhibits the initiation or processing of a claim;

   C. The procedures do not preclude an authorized representative from acting on behalf of a claimant in pursuing a claim or an appeal; (However, the plan may establish reasonable procedures for determining whether a person is authorized to act on behalf of a claimant);

   D. The procedures contain processes and safeguards to ensure and verify claim determinations are made in accordance with plan documents and are that plan provisions are applied consistently; and

   E. The claims procedures comply with the requirements of the rule regarding applicable time frames and the content of notifications of adverse determinations.

2. Time Frames for Claim Determinations. Every group health plan must make a determination regarding a claim for benefits as follows:

   A. Claims involving urgent care:

      (1) "Claims involving urgent care" means "any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

         a. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

         b. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim."

(2) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" must be treated as such.

(3) The plan must notify the claimant of its determination as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim.

B. Pre-service claims:

(1) "Pre-service claims" means "any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care."

(2) The plan must notify the claimant of its determination (whether adverse or not) within a reasonable period time appropriate to the medical circumstances, but not later than **15 days** after receipt of the claim.

(3) The plan may extend the initial time period once for up to **15 days** if the extension is necessary due to matters beyond the control of the plan.

C. Post-service claims:

(1) "Post-service claims" means "any claim for a benefit a under a group health plan that is not a pre-service claim."

(2) The plan must notify the claimant of an adverse determination within a reasonable period of time, but not later than **30 days** after receipt of the claim;

(3) The plan may extend the initial period once for up to **15 days** if the extension is necessary due to matters beyond the control of the plan.

3. Content of Claim Notification. Every group health plan must provide a claimant with a written or electronic notification of any adverse benefit determination which contains:

A. The reason(s) for adverse determinations;

B. The specific plan provisions on which the determination is based;

C. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the information is necessary;

D. A description of the plan's appeal procedures and the time frames applicable to those procedures;

E. Either a copy of any specific rule or guideline relied on by the plan in making the determination or a statement that the rule or guideline was used and will be provided free of charge;

F. If the adverse determination is based on medical necessity or other exclusion or limit involving medical judgment, either an explanation of the scientific or clinical judgment for the determination or a statement that the scientific or clinical judgement will be provided free of charge;

G. If the claim involved urgent care, a description of the plan's expedited appeal process.

4. Appeals from Adverse Determinations. Every plan must establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination and under which there will be a full and fair review of the claim and the adverse benefit determination. The appeal procedures for a group health plan will be deemed reasonable only if the procedures:

A. Provide the claimant to submit written comments, documents, records, and other information relating to the claim;

B. Provide the claimant access, upon request and free of charge, access to, and copies of, all relevant information to the claim;

C. Provide for a review that takes into account all comments, documents and other information submitted by the claimant relating to the claim;

D. Provide at least **180 days** following receipt of a notification of an adverse benefit determination in which to appeal;

E. Provide for a review that does not defer to the initial determination and is conducted by an individual who is neither the individual who made the initial determination nor that persons subordinate;

5. Time Frames Governing Appeals.

A. Urgent Care Claims. The plan must make a determination on review and notify the claimant as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the request for review.

B. Pre-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of the request for review.

C. Post-service Claims. The plan must make a determination on review and notify the claimant within a reasonable period of time, but not later than **60 days** after receipt of the request for review.

6. Content of Appeal Notification. Every group health plan must provide a claimant with a written or electronic notification of its determination on appeal which contains:

A. The specific reason(s) for the adverse determination;

B. A reference to the specific plan provisions on which the benefit determination is based;

C. A statement that the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents and information relevant to the claim;

D. A statement describing any voluntary appeal procedures offered by the plan;

E. Either a copy of any specific rule or guideline relied on by the plan in making the determination or a statement that the rule or guideline was used and will be provided free of charge;

F. If the adverse determination is based on medical necessity or other exclusion or limit involving medical judgment, either an explanation of the scientific or clinical judgment for the determination or a statement that the scientific or clinical judgement will be provided free of charge;

G. If the claim involved urgent care, a description of the plan's expedited appeal process.

7. Preemption of State Law. The Department of Labor regulation does not preempt state law regulating insurance except to the extent the state law "prevents the application of a requirement of" the regulation.