CHAPTER 26.1-26.4
HEALTH CARE SERVICE UTILIZATION REVIEW

26.1-26.4-01. Purpose and scope.

This chapter applies to grandfathered health plans unless a health care insurer or utilization review agent determines to extend the protections of section 26.1-36-47 to a grandfathered plan. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. The purpose of this chapter is to:

1. Promote the delivery of quality health care in a cost-effective manner;
2. Assure that utilization review agents adhere to reasonable standards for conducting utilization review;
3. Foster greater coordination and cooperation between health care providers and utilization review agents;
4. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and
5. Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws.

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.
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.

26.1-26.4-03. Certification.

A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 26.1-26.4-04. Certification must be made annually on or before March first of each calendar year. In addition, a utilization review agent must file the following information:

1. The name, address, telephone number, and normal business hours of the utilization review agent.
2. The name and telephone number of a person for the commissioner to contact.
3. A description of the appeal procedures for utilization review determinations.
4. A list of the third-party payers for whom the private review agent is performing utilization review in the state.

A provider may request that a utilization review agent furnish the provider with the medical review criteria to be used in evaluating proposed or delivered health care services. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

26.1-26.4-04. Minimum standards of utilization review agents.

All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.
2. Any determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.
3. Any notification of a determination not to certify an admission or service or procedure must include the information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.
4. Utilization review agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the utilization review agent. The appeal procedure must provide for the following:
   a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be made by a physician or, if appropriate, a licensed psychologist.
   b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.
   c. Utilization review agents shall provide for an expedited appeals process complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1.
5. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.
6. Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.
7. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.
8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

9. When conducting utilization review or making a benefit determination for emergency services:
    a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.
    b. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.
10. When an initial appeal to reverse a determination is unsuccessful, a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate.

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.

26.1-26.4-04.1. Utilization review in this state - Conditions of employment.

A utilization review agent is deemed to be conducting utilization review in this state if the agent conducts utilization review involving services rendered or to be rendered in the state regardless of where the agent actually performs the utilization review. No person may be employed or compensated as a private review agent under any agreement or contract when compensation of the review agent is contingent upon a denial or reduction in the payment for hospital, medical, or other health care services.

26.1-26.4-04.2. Utilization review - Duty of health care insurers.

A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

26.1-26.4-05. Utilization review agent violations - Penalty.

Whenever the commissioner has reason to believe that a utilization review agent subject to this chapter has been or is engaged in conduct that violates section 26.1-26.4-03 or 26.1-26.4-04, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty days from the date the notice is received to respond to the alleged violation.

If the commissioner believes that the utilization review agent has violated this chapter, or is not satisfied that the alleged violation has been corrected, the commissioner shall conduct a hearing on the alleged violation in accordance with chapter 28-32.

If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this chapter, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the utilization review agent a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

1. Payment of a penalty of not more than ten thousand dollars for a violation that occurred with such frequency as to indicate a general business practice; or
2. Suspension or revocation of the authority to do business in this state as a utilization review agent if the utilization review agent knew that the act was in violation of this chapter.