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Fifty-ninth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT with Senate Amendments

ENGROSSED HOUSE BILL NO. 1206

Introduced by

Representatives Porter, Devlin, Price

Senators Dever, J. Lee

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to provider appeals of medical assistance reimbursement denials; and to amend and reenact section 50-24.1-15 of the North Dakota Century Code, relating to prehospital emergency medical services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-24.1-15 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-15. Prehospital emergency medical services. Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist.

SECTION 2. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Provider appeals - Definitions.

1. For purposes of this section:

   a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided.

b. "Department" means the department of human services.

c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.

2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.

4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.

5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. The department's final decision must conform to the requirements of section 28-32-39. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an

appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.