**20:06:53:01.  Definitions.** Terms used in this chapter mean:

 (1)  "Adverse determination," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is an adverse determination;

 (2)  "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

 (3)  "Authorized representative," any person to whom a covered person has given express written consent to represent the covered person in an external review; any person authorized by law to provided substituted consent for a covered person; or any family member of the covered person or the covered person's treating health care professional, but only if the covered person is unable to provide consent;

 (4)  "Best evidence," evidence based on:

 (a)  Randomized clinical trials;

 (b)  If randomized clinical trials are not available, cohort studies or case-control studies;

 (c)  If subsections (a) and (b) are not available, case-series; or

 (d)  If subsections (a), (b), and (c) are not available, expert opinion;

 (5)  "Case-control study," a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;

 (6)  "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

 (7)  "Case-series," an evaluation of a series of patients with a particular outcome, without the use of a control group;

 (8)  "Certification," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

 (9)  "Clinical review criteria," the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services;

 (10)  "Cohort study," a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention;

 (11)  "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment;

 (12)  "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

 (13)  "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

 (14)  "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

 (15)  "Disclose," to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;

 (16)  "Emergency medical condition," the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

 (17)  "Emergency services," health care items and services furnished or required to evaluate and treat an emergency medical condition;

 (18)  "Evidence-based standard," the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;

 (19)  "Expert opinion," a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy;

 (20)  "Facility," an institution providing health care services or a health care setting, including, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings;

 (21)  "Final adverse determination," an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in SDCL 58-17I-1 to 58-17I-16, inclusive;

 (22)  "Health benefit plan," a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

 (23)  'Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law;

 (24)  "Health care provider" or "provider," a health care professional or a facility;

 (25)  "Health care services," services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease;

 (26)  "Health information," information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

 (a)  The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

 (b)  The provision of health care services to an individual; or

 (c)  Payment for the provision of health care services to an individual;

 (27)  "Independent review organization," an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

 (28)  "Medical or scientific evidence," evidence found in the following sources:

 (a)  Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

 (b)  Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

 (c)  Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

 (d)  The following standard reference compendia:

 (i)    The American Hospital Formulary Service-Drug Information;

 (ii)   Drug Facts and Comparisons;

 (iii)  The American Dental Association Accepted Dental Therapeutics; and

 (iv)  The United States Pharmacopoeia-Drug Information;

 (e)  Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

 (i)     The federal Agency for Healthcare Research and Quality;

 (ii)    The National Institutes of Health;

 (iii)   The National Cancer Institute;

 (iv)   The National Academy of Sciences;

 (v)    The Centers for Medicare & Medicaid Services;

 (vi)   The federal Food and Drug Administration; and

 (vii)  Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

 (f)  Any other medical or scientific evidence that the director determines is comparable to the sources listed in subsections (a) to (e), inclusive;

 (29)  "NAIC," the National Association of Insurance Commissioners;

 (30)  "Prospective review," utilization review conducted prior to an admission or a course of treatment;

 (31)  "Protected health information," health information:

 (a)  That identifies an individual who is the subject of the information; or

 (b)  With respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

 (32)  "Randomized clinical trial," a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

 (33)  "Retrospective review," a review of medical necessity 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;

 (34)  "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service;

 (35)  "Utilization review," a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review;

 (36)  "Utilization review organization," an entity that conducts utilization review, other than a health carrier performing a review of its own health benefit plan.

 **Source:** 37 SDR 48, effective September 22, 2010; 37 SDR 241, effective July 1, 2011.

 **General Authority:** SDCL 58-17-87, 58-17H-49, 58-17I-16, 58-18-79.

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