

**§ 97-25.3. Preauthorization.**

(a) An insurer may require preauthorization for inpatient admission to a hospital, inpatient admission to a treatment center, and inpatient or outpatient surgery. The insurer's preauthorization requirement must adhere to the following standards:

- (1) The insurer may require no more than 10 days advance notice of the inpatient admission or surgery.
- (2) The insurer must respond to a request for preauthorization within two business days of the request.
- (3) The insurer shall review the need for the inpatient admission or surgery and may require the employee to submit to an independent medical examination as provided in G.S. 97-27(a). This examination must be completed and the insurer must make its determination on the request for preauthorization within seven days of the date of the request unless this time is extended by the Commission for good cause.
- (4) The insurer shall document its review findings and determination in writing and shall provide a copy of the findings and determination to the employee and the employee's attending physician, and, if applicable, to the hospital or treatment center.
- (5) The insurer shall authorize the inpatient admission or surgery when it requires the employee to submit to a medical examination as provided in G.S. 97-27(a) and the examining physician concurs with the original recommendation for the inpatient admission or surgery. The insurer shall also authorize the inpatient admission or surgery when the employee obtains a second opinion from a physician approved by the insurer or the Commission, and the second physician concurs with the original recommendation for the inpatient admission or surgery. However, the insurer shall not be required by this subdivision to authorize the inpatient admission or surgery if it denies liability under this Article for the particular medical condition for which the services are sought.
- (6) Except as provided in subsection (c) of this section, the insurer may reduce its reimbursement of the provider's eligible charges under this Article by up to fifty percent (50%) if the insurer has notified the provider in writing of its preauthorization requirement and the provider failed to timely obtain preauthorization. The employee shall not be liable for the balance of the charges.
- (7) The insurer shall adhere to all other procedures for preauthorization prescribed by the Commission.

(b) An insurer may not impose a preauthorization requirement for the following:

- (1) Emergency services;
- (2) Services rendered in the diagnosis or treatment of an injury or illness for which the insurer has not admitted liability or authorized payment for treatment pursuant to this Article; and
- (3) Services rendered in the diagnosis and treatment of a specific medical condition for which the insurer has not admitted liability or authorized payment for treatment although the insurer admits the employee has suffered a compensable injury or illness.

(c) The Commission may, upon reasonable grounds, upon the request of the employee or provider, authorize treatment for which preauthorization is otherwise required by this section

but was not obtained if the Commission determines that the treatment is or was reasonably required to effect a cure or give relief.

(d) The Commission may adopt procedures governing the use of preauthorization requirements and expeditious review of preauthorization denials.

(e) A managed care organization may impose preauthorization requirements consistent with the provisions of Chapter 58 of the General Statutes.

(f) A provider that refuses to treat an employee for other than an emergency medical condition because preauthorization has not been obtained shall be immune from liability in any civil action for the refusal to treat the employee because of lack of preauthorization. (1993 (Reg. Sess., 1994), c. 679, s. 2.2.)