HOUSE BILL 649

Short Title:	Ensure Timely/Clinically Sound Utiliz. Review.	(Public)
Sponsors:	Representatives K. Baker, Reeder, Potts, and Sasser (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

April 18, 2023

A BILL TO BE ENTITLED

AN ACT TO ENSURE TIMELY AND CLINICALLY SOUND UTILIZATION REVIEWS AND THAT MEDICAL DECISIONS ARE MADE BY HEALTH CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61 reads as rewritten:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

…

(2a) "Closely related service" means a health care service subject to utilization review that is closely related in purpose, diagnostic utility, or designated health care billing code, that was provided on the same date of service as another health care service was authorized to be performed by a previous utilization review determination, and for which a provider, acting within the scope of the provider's license and expertise, may reasonably be expected to perform in conjunction with, or in lieu of, the originally authorized service due to differences in the observed patient characteristics or needs for diagnostic information that were not readily identifiable until the provider was performing the originally authorized service. The term does not include an order for or administration of a prescription drug or any part of a series or course of treatments.

(2b) "Course of treatment" means a prescribed order or ordered course of treatment for a specific covered person with a specific condition that is outlined and decided upon ahead of time with the covered person and health care provider.

…

(5) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care transportation services, including, but not limited to, ambulance services and ancillary services routinely available to the emergency department.

…

(14a) "Prior authorization" means the process by which insurers and utilization review organizations determine the medical necessity and/or medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. Prior authorization also includes any

insurer's or utilization review organization's requirement that a covered person or health care provider notify the insurer or utilization review organization prior to providing a health care service.

…

(16a) "Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited utilization review, which, in the opinion of a medical doctor with knowledge of the covered person's medical condition could either (i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or (ii) subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. The term urgent health care service shall include mental and behavioral health care services.

(17) "Utilization review" means 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, providers, or facilities. These techniques may ~~include:~~include any of the following:

…

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of ~~treatment.~~treatment and that payment will be made for that service.

…

e1. Prior authorization.

…

(18) "Utilization review organization" or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own health benefit plan.

…

(c) Scope and Content of Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.

(2) Data sources and clinical review criteria used in decision making.

(3) The process for conducting appeals of noncertifications.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.

(7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.

(8) The staff position functionally responsible for day-to-day program management.

(9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are

~~periodically~~ evaluated at least annually to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review ~~criteria.~~ criteria, provided that the insurer's clinical review meets, at a minimum, all of the following:

(1) Is based on applicable nationally recognized medical standards.
(2) Is consistent with applicable government guidelines.
(3) Provides for the delivery of a health care service in a clinically appropriate type, frequency, and setting and for a clinically appropriate duration.
(4) Reflects the current medical and scientific evidence regarding emerging procedures, clinical guidelines, and best practices, as articulated in independent, peer-reviewed medical literature.
(5) Is sufficiently flexible to allow deviations from the norm when justified on a case-by-case basis to ensure access to care.

Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. ~~A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications.~~ Insurers must ensure that all noncertifications are made by a medical doctor possessing a current and valid license to practice medicine in this State who (i) is of the same specialty as the medical doctor who typically manages the medical condition or disease or provides the health care service involved in the request and (ii) has experience treating patients with the medical condition or disease for which the health care service is being requested. Medical doctors must issue noncertifications under the clinical direction of one of the insurer's medical directors who are responsible for the provision of health care services provided to covered persons. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(d1) Consultation Prior to Issuing Noncertifications. – If an insurer is questioning the medical necessity of a health care service, the insurer must notify the covered person's relevant provider that medical necessity is being questioned within five business days of the date the insurer received the utilization review request for the health care service in question. Prior to issuing a noncertification, the covered person's provider must be given the opportunity to discuss the medical necessity of the health care service on the telephone with the medical doctor who will be responsible for making the utilization review determination of the health care service under review.

(e) Insurer Responsibilities. – Every insurer ~~shall:~~shall do all of the following regarding its utilization review process under this section:

(1) Routinely assess the effectiveness and efficiency of its utilization review program.
(2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.

(3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.

(4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

(5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.

(6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(7) Maintain a complete list of health care services for which utilization review is required, including for all health care services where utilization review is to be performed by an entity under contract with the insurer.

(f) ~~Prospective and Concurrent~~ Utilization Reviews Based Upon Type of Health Care Service. – As used in this subsection, the term "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. ~~Prospective and concurrent~~ Utilization review determinations shall be communicated to the covered person's provider ~~within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service.~~ as follows:

(1) For non-urgent health care services: If an insurer requires a utilization review of a health care service, the insurer must make a utilization review determination or noncertification and notify the covered person and the covered person's provider within 48 hours of obtaining all necessary information to make the utilization review determination or noncertification. If a utilization review request is missing clinical information that is reasonably necessary to constitute a completed request, an insurer shall notify the provider of the specific information necessary to complete the utilization review as soon as possible, but not later than 48 hours after receipt of the initial utilization review request. The requesting provider or a member of the requesting provider's clinical or administrative staff may submit the specified information within 14 business days of the notification that clinical information is missing. If additional information is requested, the insurer shall communicate a decision on the request within two business days of receiving the additional information.

(2) For urgent health care services: An insurer must render a utilization review determination or noncertification concerning urgent health care services and notify the covered person and the covered person's provider of that utilization review determination or noncertification not later than 24 hours after receiving all necessary information needed to complete the review of the requested health care services.

(3) For emergency services: All of the following shall apply to utilization review for emergency services:

a. An insurer may not require a utilization review for prehospital transportation or the provision of emergency services.

b. An insurer shall allow a covered person and the covered person's provider a minimum period of 24 hours following an emergency admission or the provision of emergency services for the covered person or the relevant provider to notify the insurer of the admission or provision of emergency services. If the admission or emergency service occurs on a holiday or weekend, an insurer cannot require notification until the next business day after the admission or provision of the emergency services.

c. An insurer shall cover emergency services necessary to screen and stabilize a covered person. If a provider attests in writing to an insurer within 72 hours of a covered person's admission that the covered person's condition required emergency services, then that attestation will create a presumption that the emergency services were medically necessary and that presumption may be rebutted only if the insurer can establish, with clear and convincing evidence, that the emergency services were not medically necessary.

d. The medical necessity or appropriateness of emergency services cannot be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency services provided by nonparticipating providers cannot be greater than restrictions that apply when those services are provided by participating providers.

e. If a covered person receives an emergency service that requires immediate post-evaluation or post-stabilization services, an insurer shall make a utilization review determination within 60 minutes of receiving a request. If the authorization determination is not made within 60 minutes, then the services for which the utilization review was requested shall be deemed approved.

(f1) Utilization Review Requests for Additional Information. – If an insurer requests additional information to process a claim subject to utilization review, the insurer must ensure that the request informs the provider of the specific information being requested and the specific purpose of the request, references all relevant clinical and administrative criteria, and is written in easily understandable language. Insurers shall adjudicate any claim subject to a request for additional information to process a claim within the time periods for prompt payment of claims pursuant to G.S. 58-3-225.

(f2) Utilization Review Determination Notifications. – If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification. An insurer shall make a concurrent review determination within 24 hours of obtaining all necessary information from the provider or heath care facility.

(f3) Failure to Make a Timely Utilization Review Determination. – An insurer failing to approve, deny, or request additional information for a requested utilization review within the applicable time frames shall be deemed to have approved the request.

(g) Retrospective Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give

written notification to the covered person and the covered person's provider within five business days after making the noncertification.

(g1) Retrospective Denial. – An insurer may not revoke, limit, condition, or restrict a utilization review determination if care is provided within 45 business days from the date the provider received the utilization review determination. An insurer must pay a provider at the contracted payment rate for a health care service provided by the provider per a utilization review determination unless any of the following apply:

(1) The provider knowingly and materially misrepresented the health care service in the utilization review request with the specific intent to deceive and obtain an unlawful payment from the insurer.

(2) The health care service was no longer a covered benefit on the day it was provided.

(3) The provider was no longer contracted with the covered person's health insurance plan on the date the care was provided.

(4) The provider failed to meet the insurer's timely filing requirements.

(5) The insurer does not have liability for the claim.

(6) The covered person was no longer eligible for health care coverage on the day the care was provided.

(h) Requirements for Notice of Noncertification. – A written notification of a noncertification made in accordance with this section shall include all reasons for the noncertification, including the clinical rationale, the name and medical specialty of all medical doctors that were involved in the noncertification, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~program.

(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with ~~subsection (h) of~~ this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice ~~in accordance with subsection (h)~~ that meets the requirements of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

(j1) Requirements Applicable to Appeals Reviews. – All appeals must be reviewed by a medical doctor who meets all of the following criteria:

(1) Possesses a current and valid non-restricted license to practice medicine in this State.

(2) Is currently in active practice for a period of at least five consecutive years in the same or similar specialty as a medical doctor who typically manages the medical condition or disease for which utilization review is required.

(3) Is knowledgeable of, and has experience providing, the health care services under appeal.

(4) Has not been directly involved in making the adverse determination.

As part of the appeals review, the medical doctor shall consider all known clinical aspects of the health care service under review, including, but not limited to, all pertinent medical records that have been provided to the insurer by the covered person's provider, any relevant records provided to the insurer by a health care facility, and any medical literature provided to the insurer by the provider.

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall ~~contain:~~contain all of the following information:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.

(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.

(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.

(6) Notice of the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~program.

(*l*) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or ~~his or her~~ the provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure of Review of Utilization Review Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~ program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes. An insurer shall make any current utilization review requirements and restrictions readily accessible on its website. Requirements shall be described in detail but also in easily understandable language.

If an insurer intends either to implement a new utilization review requirement or restriction or amend an existing requirement or restriction, all of the following apply:

(1) The insurer shall not implement the new or amended requirement unless the insurer's website has been updated to reflect the new or amended requirement or restriction.

(2) The insurer shall provide contracted providers written notice of the new or amended requirement or amendment no less than 60 calendar days before the requirement or restriction is implemented.

(m1) Utilization Review Statistics. – Insurers using utilization review shall make statistics available regarding utilization review approvals and noncertifications on their website in a readily accessible format. These statistics shall include categories for all of the following:

(1) Medical doctor specialty.

(2) Medication or diagnostic test or procedure.

(3) Indication offered.

(4) Reasons for denial.

(5) The number of utilization review determinations appealed and the number approved or denied on appeal.

(6) The average time between submission and response.

(n) Maintenance of Records. – Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of five years or, for domestic companies, until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(n1) Utilization Review Determination Validity. – A utilization review determination shall be valid for the entire duration of the approved course of treatment and shall be effective regardless of any changes in dosage for a prescription drug prescribed by a provider. If an insurer requires a utilization review determination for a health care service for the treatment of a chronic or long-term care condition, the utilization review determination shall remain valid for the length of the treatment and the insurer may not require the covered person to obtain a utilization review determination again for the health care service.

(n2) Continuity of Care. – The following requirements shall apply to ensure continuity of care for covered persons:

(1) On receipt, from a covered person or the covered person's provider, of information documenting a prior utilization review determination, an insurer shall honor a utilization review determination granted to the covered person from a previous insurer for at least 90 calendar days of a covered person's

coverage under a new health benefit plan. During this 90-day time period, an insurer may perform its own utilization review.

(2) If the insurer makes a change in coverage of, or approval criteria for, a previously authorized health care service, then the change in coverage or approval criteria shall not affect a covered person who received a utilization review determination before the effective date of the change for the remainder of that covered person's health benefit plan year.

(3) An insurer shall continue to honor a utilization review determination it has granted to a covered person when that covered person changes products or health benefit plans under the same insurer, provided that the medically necessary services or supplies subject to the utilization review determination do not change.

(4) If a provider performs a health care service closely related to the service for which approval has already been granted, an insurer may not deny a claim for the closely related service for failure of the provider to seek or obtain a utilization review if the provider had notified the insurer of the performance of the closely related service no later than three business days following the completion of the closely related service, but prior to the submission of the claim for payment for that service. The submission of the notification shall include the submission of all relevant clinical information necessary for the insurer to evaluate the medical necessity of the service. Nothing in this subsection shall be construed to limit an insurer's retrospective review of medical necessity of the closely related service nor limit the need for verification of the covered person's eligibility for coverage under the health benefit plan.

(5) An insurer shall not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child (i) following a normal vaginal delivery to less than 48 hours or (ii) following a cesarean section to less than 96 hours. An insurer shall not require that a health care provider obtain a utilization review determination from an insurer for prescribing the length of stay required under this subdivision.

(o) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70.

(p) Exemptions. – An insurer may not require a provider to request a utilization review for a health care service in order for the covered person to whom the health care service is being provided to receive coverage if, within the most recent 12-month period, the insurer has issued certifications, or would have issued certifications, for not less than eighty percent (80%) of the utilization review requests submitted by the provider for that health care service, provided that this subsection shall not apply to utilization review requests that are pending review by an insurer. An insurer may evaluate whether a provider continues to qualify for this exemption not more than once every 12 months. The following shall apply to an exemption under this subsection:

(1) A provider is not required to request an exemption in order to qualify for an exemption.

(2) A provider who does not receive an exemption may request from the insurer at any time, but not more than once per year per service, evidence to support the insurer's decision. A health care provider may appeal an insurer's decision to deny an exemption.

(3) An insurer may only revoke an exemption at the end of the 12-month period if the insurer does all of the following:

a. Makes a determination that the provider would not have met the eighty percent (80%) approval criteria based on a retrospective review of the claims for the particular service for which the exemption applies for

the previous three months or for a longer period if needed to reach a minimum of 10 claims for review.

b. Provides the provider with the information the insurer relied upon in making the determination to revoke the exemption.

c. Provides the provider a plain language explanation of how to appeal the decision.

(4) An exemption remains in effect until the thirtieth calendar day after the date the insurer notifies the provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth calendar day after the revocation is upheld on appeal.

(5) A determination to revoke or deny an exemption must be made by a provider licensed in this State of the same or similar specialty as the provider being considered for an exemption and have experience in providing the service for which the potential exception applies.

(6) An insurer must provide a health care provider that receives an exemption a notice that includes all of the following:

a. A statement that the provider qualifies for an exemption from preauthorization requirements.

b. A list of services for which the exemption applies.

c. A statement of the duration of the exemption.

(7) An insurer shall not deny or reduce payment for a health care service exempted from a utilization review requirement under this subsection, including a health care service performed or supervised by another provider when the provider who ordered the service received an exemption, unless the rendering provider meets one of the following criteria:

a. Knowingly and materially misrepresented the health care service in request for payment submitted to the insurer with the specific intent to deceive and obtain an unlawful payment from the insurer.

b. Failed to substantially perform the health care service.

Nothing in this subsection requires an insurer to evaluate an existing exemption or prevents an insurer from establishing a longer exemption period.

(q) Deemed Approval. – Any failure by an insurer to comply with the deadlines and other requirements specified in this section will result in any health care services subject to review to be automatically deemed authorized by the insurer."

SECTION 2. This act becomes effective January 1, 2024, and applies to insurance contracts issued, renewed, or amended on or after that date.