HOUSE BILL 649:
Ensure Timely/Clinically Sound Utiliz. Review.

2023-2024 General Assembly

Committee:	House Health. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	April 25, 2023
Introduced by:	Reps. K. Baker, Reeder, Potts, Sasser	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	First Edition		

OVERVIEW: House Bill 649 would amend the utilization review process by creating requirements for noncertification, notification and determination time frames, retrospective denials, appeals review, continuity of care, and exemptions.

BILL ANALYSIS:

Definitions: Definitions found in G.S. 58-50-61 for "closely related service", "course of treatment", "prior authorization", and "urgent health care service" would be created. The definition of "emergency services" would be amended to include prehospital care transportation services. The definition of "utilization review" would be amended to include prior authorization, and concurrent review would be amended to include payment will be made for that service.

Program Operations: Insurers or utilization review organizations (URO) would be required to evaluate clinical review at least annually, previously was periodically. An insurer's clinical review would have to meet five specified criteria.

Noncertification: A noncertification means that a proposed course of treatment is not medically necessary. An insurer would have to ensure that a medical doctor issuing a noncertification is (i) currently licensed in the State in the same specialty as the doctor providing the health care services in the request and (ii) has experience treating patients with the medical condition. The noncertification would be issued under the clinical direction of one of the insurer's medical directors. Notice would be required to a covered person if an insurer was questioning medical necessity, and the provider would be allowed to speak with the doctor performing the utilization review determination.

Insurer Responsibilities: An insurer would maintain a list of health care services for which utilization review is required.

Utilization Reviews Based on Type of Health Care: Prospective and concurrent utilization review determinations are required to be communicated within three business days after receiving necessary information. Utilization review determination would be made as follows after obtaining all necessary information (i) within 48 hours for non-urgent health care services, (ii) not later than 24 hours for urgent health care services, and (iii) within 60 minutes of receiving a request for emergency services that require immediate post-evaluation or post-stabilization services. It would specify further requirements for utilization review of emergency services.

Request for Additional Information: The information an insurer must communicate to a provider when requesting additional information for a utilization review is specified. An insurer would be required to adjudicate any claim subject to a request for additional information to process a claim pursuant to G.S. 58-3-225 (Prompt claim payments under health benefit plans).

Utilization Review Determination Notifications: An insurer would be required to make a concurrent review determination within 24 hours of obtaining all necessary information. An insurer who fails to make a determination within the applicable time frame would be deemed to have approved the request.

Retrospective Denial: An insurer could not revoke, limit, condition, or restrict a utilization review determination pursuant to a utilization review within 45 business days from the date the provider received the determination unless any of the exception apply.

Notice of Noncertification and Appeal: A written notification of noncertification would be required to include the name and medical specialty of all medical doctors involved in the noncertification. All appeals would be review by a doctor who meets specified criteria. The doctor would consider all known clinical aspects of the health care service under review.

Disclosure for Review and Statistics: An insurer would be required to post on its website current utilization review requirements in an easily understandable language, and the website must be updated with any changes. Written notice of the new or amended requirements would be provided to contracted providers no less than 60 days prior to implementation. Insurers would make utilization review statistics regarding approvals and noncertifications available on their website for specified categories.

Utilization Review Determination Validity: A utilization review determination would be valid for the entire duration of the approved course of treatment and effective regardless of any changes in dosage for a prescription drug.

Continuity of Care: The following would apply to ensure continuity of care: (i) requires an insurer to honor a utilization review determination granted to the covered person from a previous insurer with certain parameters; (ii) a change in coverage or approval criteria for a previously authorized healthcare service will not affect a covered person who received a utilization review determination before the effective date of the change for the remainder of the covered person's health benefit plan year; (iii) requires coverage of a service previously granted under a utilization review if a covered person changes under the same insurer, with certain provisions; (iv) 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 meets notification requirements; and (v) prohibits an insurer from restricting specified benefits related to childbirth.

Exemptions: A utilization review may not be required if, within the past 12 months, the insurer has issued certifications to the provider for no less than 80% percent of the utilization review requests for that health care service, then an insurer may not require the provider to request a utilization review. Once every 12 months, this exemption would be evaluated by the insurer. A provider would not be required to request an exemption, and an insurer may only revoke an exemption under certain circumstances. A provider who doesn't receive an exemption would be able to request evidence of why from the insurer.

A time frame would be specified for how long an exemption remains in place past an insurer's decision to revoke the exemption. Decisions on exemptions would be made by providers licensed in the State with the same or similar specialty as the provider being considered for the exemption and with experience in providing the services for which the potential exception applies. An insurer who receives an exemption would be provided specified notice. An insurer could not deny or reduce payment for a health care service exempted from utilization review requirement unless certain circumstances occur.

Deemed Approval: Any failure to comply by an insurer would result in health care services subject to review automatically being deemed authorized by the insurer.

EFFECTIVE DATE: This act would be effective January 1, 2024, and apply to insurance contracts issued, renewed, or amended on or after that date.