

24-A §4304. UTILIZATION REVIEW

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The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering or renewing a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34. [2007, c. 199, Pt. B, §12 (AMD).]

1. Requirements for medical review or utilization review practices. A carrier must appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter.

[2007, c. 199, Pt. B, §13 (AMD) .]

2. Prior authorization of nonemergency services. Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

[1999, c. 742, §12 (AMD) .]

3. Background information; affirmative duty of provider. A provider has an affirmative duty to submit to the carrier the background information necessary for the carrier to complete its review and render a decision within the time period required in subsection 2. If the provider needs additional time to submit that required information, the provider must inform the carrier in a timely manner. Nothing in this section requires a provider to submit confidential information without a signed consent from the enrollee.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

4. Revocation of prior authorization. When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

5. Emergency services. When conducting utilization review or making a benefit determination for emergency services, a carrier shall provide benefits for emergency services consistent with the requirements of any applicable bureau rule.

[1999, c. 742, §13 (NEW) .]

6. Notice. A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the policy or contract under which the insured or enrollee is covered. Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.

[2001, c. 410, Pt. B, §6 (NEW) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§11-13 (AMD). 2001, c. 288, §6 (AMD). 2001, c. 410, §B6 (AMD). 2007, c. 199, Pt. B, §§12, 13 (AMD).

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