PATIENT PROTECTION ALLIANCE

HB 649
ENSURE TIMELY AND CLINICALLY SOUND UTILIZATION REVIEWS

HB 649 requires that medical decisions for patients be made by health care providers and based on the most effective treatment. This bill was passed by the House and awaits hearing by the Senate. The bill also requires the following:

PLAIN LANGUAGE

Requires insurers to make utilization review requirements and restrictions easy to understand and accessible to the public. Requires that information requests from insurers are clear and specific so that doctors can respond with meaningful and satisfactory information and limits the timeframe for retrospective denials. Also requires that insurers follow procedures for updating review requirements in a manner that adequately informs patients and doctors prior to the updates taking effect.

MINIMUM / CURRENT STANDARDS

Requires insurers to update their clinical review criteria at least annually and sets minimum requirements for clinical standards.

TALK WITH A PHYSICIAN

Requires that insurers consult with the patients' physician prior to refusing to pay for the prescribed medical care, if the medical necessity for the care is being questioned.

TIMELY DECISIONS

Sets time limits for utilization reviews based on medical care level (non-urgent, urgent, emergency) and provides timeframes in which insurers must make decisions based on the urgency of the need for treatment.

REVIEW / APPEAL STANDARDS

Requires physicians conducting utilization reviews and issuing denials for prescribed medical care and conducting appeals must be of the appropriate specialty for the patient's diagnosis. Reviewing physicians must also have experience treating patients with the condition or service being reviewed. Physicians deciding appeals must be licensed in NC, in active practice, in the same or similar specialty and have experience treating the condition and providing the service involved in the appeal.

CONTINUITY OF CARE

Adds requirements designed to promote continuity of care for covered patients, including honoring authorizations granted from previous insurers for a time and ensuring coverage for closely related services.

RETROSPECTIVE DENIALS

Sets limits on when retrospective denials can take place so that an insurer cannot refuse to pay for an approved service that is provided within 45 days of approval and required payment at the contracted rate except in the case of fraud, the service is no longer covered, and other standard putting the service outside the scope of the contract.

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