§4304. Utilization review

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. [PL 2007, c. 199, Pt. B, §12 (AMD).]

1. Requirements for medical review or utilization review practices. A carrier shall 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. A carrier shall provide clear written policies and procedures to providers and enrollees on how to obtain a prior authorization.
[PL 2023, c. 275, §1 (AMD).]

2. Prior authorization of nonemergency services. Except for a request in exigent circumstances as described in section 4311, subsection 1-A, paragraph B, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection.

A. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. [PL 2019, c. 273, §1 (NEW).]

B. If the carrier responds to a request by a provider for prior authorization with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information. [PL 2019, c. 273, §1 (NEW).]

C. If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response. [PL 2019, c. 273, §1 (NEW).]

D. The prescription drug and prior authorization standards used by a carrier must be clear and readily available to enrollees, participating providers, pharmacists and other providers. With regard to prior authorization for prescription drugs, a carrier shall comply with the requirements set forth in subsection 2-B. A provider must make best efforts to provide all information necessary to evaluate a request, and the carrier must make best efforts to limit requests for additional information. [PL 2021, c. 73, §1 (AMD).]

E. If a covered medically necessary service cannot be delivered on the approved date of an approved prior authorization request, a carrier may not deny the claim if the covered medically necessary service is provided within 14 days before or after the approved date. [PL 2023, c. 680, Pt. A, §4 (NEW); PL 2023, c. 680, Pt. A, §10 (AFF).]

F. For nonemergency services provided without a required prior authorization approval, a carrier may not deny a claim for nonemergency services that were within the scope of the enrollee's coverage pending medical necessity review and may not impose a penalty on the provider for failing to obtain a prior authorization of greater than 15% of the contractually allowed amount for the services that required prior authorization approval. [PL 2023, c. 680, Pt. A, §5 (NEW); PL 2023, c. 680, Pt. A, §10 (AFF).]

If a carrier does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted.
[PL 2023, c. 680, Pt. A, §§4, 5 (AMD); PL 2023, c. 680, Pt. A, §10 (AFF).]

2-A. Prior authorization of medication-assisted treatment for opioid use disorder. A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose any prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder. For the purposes of this subsection, "medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling.
[PL 2019, c. 273, §2 (NEW).]

2-B. Electronic transmission of prior authorization requests. If a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests in accordance with subsection 2 and this subsection through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. For the purposes of this subsection, transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission. A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the following.

A. No later than January 1, 2022, unless a waiver is granted by the superintendent, a carrier or entity under contract to a carrier shall make available to a provider in real time at the point of prescribing one or more electronic benefit tools that are capable of integrating with at least one electronic prescribing system or electronic medical record system to provide complete, accurate, timely, clinically appropriate formulary and benefit information specific to an enrollee, including, but not limited to, the estimated cost-sharing amount to be paid by the enrollee, information on any available formulary alternatives that are clinically appropriate and information about the formulary status and the utilization review and prior authorization requirements of each drug presented. Upon a carrier's request, the superintendent may grant a waiver from the requirements of this paragraph based on a demonstration of good cause. [PL 2021, c. 73, §2 (NEW).]

B. No later than January 1, 2023, unless a waiver is granted by the superintendent, a carrier or entity under contract to a carrier shall make available to a provider in real time at the point of prescribing an electronic benefit tool that is capable of integrating with the provider's electronic prescribing system or electronic medical record system to provide complete, accurate, timely, clinically appropriate formulary and benefit information specific to an enrollee, including, but not limited to, the estimated cost-sharing amount to be paid by the enrollee, information on any available formulary alternatives that are clinically appropriate and information about the formulary status and the utilization review and prior authorization requirements of each drug presented. Upon a carrier's request, the superintendent may grant a waiver from the requirements of this paragraph based on a demonstration of good cause. [PL 2021, c. 73, §2 (NEW).]

[PL 2021, c. 73, §2 (AMD).]

2-C. Prior authorization of prescription drugs used for assessment and treatment of serious mental illness. Notwithstanding any requirement of this section to the contrary, a carrier shall approve a prior authorization request for medication on the carrier's prescription drug formulary that is prescribed to assess or treat an enrollee's serious mental illness. For the purposes of this subsection, "serious mental illness" means a mental disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities. The superintendent may adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 345, §1 (NEW).]

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.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 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.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 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 this subsection and any applicable bureau rule.

A. Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board-certified emergency physician who is licensed in this State, including a review of the enrollee's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of or payment reduction for an enrollee's benefits when emergency services were furnished to an enrollee, a provider has an affirmative duty to respond to the carrier in a timely manner. This paragraph does not apply when a reduction in payment is made by a carrier based on a contractually agreed upon adjustment for health care service. [PL 2019, c. 238, §2 (NEW).]

B. The medical necessity of emergency services may not be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency services provided by nonparticipating providers may not be greater than restrictions that apply when those services are provided by participating providers. [PL 2023, c. 680, Pt. A, §6 (NEW); PL 2023, c. 680, Pt. A, §10 (AFF).]

C. If an enrollee receives an emergency service that requires immediate post-evaluation or post-stabilization services, a carrier may not require prior authorization for the post-evaluation or post-stabilization services provided during the same encounter. If the post-evaluation or post-stabilization services require an inpatient level of care, the carrier shall make a utilization review determination within 24 hours of receiving a request for those services and the carrier is responsible for payment for those services for the duration until the carrier affirmatively notifies the provider otherwise. If the utilization review determination is not made within 24 hours, the services for which the utilization review was requested are deemed approved until the carrier affirmatively notifies the provider otherwise. [PL 2023, c. 680, Pt. A, §7 (NEW); PL 2023, c. 680, Pt. A, §10 (AFF).]
[PL 2023, c. 680, Pt. A, §§6, 7 (AMD); PL 2023, c. 680, Pt. A, §10 (AFF).]

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.
[PL 2001, c. 410, Pt. B, §6 (NEW).]

7. Requirements for an appeal of adverse health care treatment decision. An appeal of a carrier's adverse health care treatment decision must be conducted by a clinical peer. The clinical peer

may not have been involved in making the initial adverse health care treatment decision unless additional information not previously considered during the initial review is provided on appeal. For the purposes of this subsection, "adverse health care treatment decision" does not include a carrier's rescission determination or a carrier's determination of initial coverage eligibility for coverage.
[PL 2019, c. 171, §2 (NEW).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §§11-13 (AMD). PL 2001, c. 288, §6 (AMD). PL 2001, c. 410, §B6 (AMD). PL 2007, c. 199, Pt. B, §§12, 13 (AMD). PL 2019, c. 171, §2 (AMD). PL 2019, c. 238, §2 (AMD). PL 2019, c. 273, §§1, 2 (AMD). PL 2021, c. 73, §§1, 2 (AMD). PL 2021, c. 345, §1 (AMD). PL 2023, c. 275, §1 (AMD). PL 2023, c. 680, Pt. A, §§4-7 (AMD). PL 2023, c. 680, Pt. A, §10 (AFF).