SECTION .1000 – PREAUTHORIZATION FOR MEDICAL TREATMENT

04 NCAC 10A .1001 PREAUTHORIZATION FOR SURGERY AND INPATIENT TREATMENT

(a) An insurer that requires preauthorization must establish a preauthorization review policy that describes the process for requesting preauthorization review. The policy must be publicly available on the insurer's website.

(b) As used in this Section:

(1) "insurer" means an insurance carrier, self-insured administrator, managed care organization, employer, or any other entity that conducts preauthorization review;

(2) "preauthorization" means the determination by an insurer that proposed surgical or inpatient treatment is medically necessary; and

(3) "preauthorization review" means a prospective review process conducted by an insurer to determine whether a proposed surgical or inpatient treatment is medically necessary.

(c) Insurers shall, on an annual basis, electronically submit an electronic copy or link for any medical practice guidelines the insurer utilizes in the preauthorization review process to the Commission at the following electronic site (ftp://ftp.ic.nc.gov) by July 1 of each year.

(d) The insurer shall list each surgical procedure and each inpatient service for which preauthorization review is required. These procedures and services shall be publicly available on the insurer's website.

(e) The preauthorization review policy shall include:

(1) procedures for requesting preauthorization, responding to and approving requests for preauthorization, and appealing a denial of preauthorization;

(2) procedures via telephone, fax and email for communicating with the preauthorization agent with decision making powers on a pending request for preauthorization (including Peer Review Physicians) on a continuous basis on every business day (which excludes weekends and holidays) between the hours of 8:00 a.m. and 8:00 p.m. eastern standard time;

(3) methods by which the insurer shall respond to requests for preauthorization and methods by which a health care provider, claimant, person, or entity requesting preauthorization may respond to inquiries or determinations by the insurer;

(4) a statement that the insurer will provide a statement with supporting documentation of the substantive clinical justification for a denial of preauthorization, including the relevant clinical criteria upon which the denial is based. Denials based upon lack of information shall specify what information is needed to make a determination;

(5) an outline of the appeal rights and procedures with instructions on how to submit appeals by mail, email or fax;

(6) a statement that advises the appealing party of the right to seek authorization for any denied treatment from the Commission; and

(7) the name, title, address, telephone number, fax number, email address and other contact information for the person with authority over all decision-making for preauthorization determinations (in addition to the claims adjuster), and the normal business hours and time zone of this contact person.

(f) Delivery of a request for preauthorization to the claims adjuster or other designated Preauthorization Agent at the place (email address, fax number, telephone number) provided by the insurer shall constitute receipt of the preauthorization request by the claims adjuster.

(g) Preauthorization agents shall acknowledge receipt of all communications within two business days of the request, and the acknowledgment shall satisfy G.S. 97-25.3(a)(2).

(h) Upon receipt of a request for preauthorization, the insurer shall provide to the health care provider or person making the request the name, telephone number, fax number and email address of the Preauthorization Agent. The Preauthorization Agent must be available on a continuous basis, every business day (which excludes weekends and holidays) from 8:00 a.m. to 8:00 p.m. Eastern Standard Time to facilitate responses to insurer communications or determinations.

(i) Insurers that utilize a Peer Review Physician in making preauthorization decisions shall indicate in their preauthorization review policy the name, licensure, and specialty area of that Peer Review Physician and shall provide a profile ("Peer Review Physician Profile") of that Peer Review Physician. The Peer Review Physician shall be licensed in either North Carolina, South Carolina, Georgia, Virginia, or Tennessee and shall hold professional qualifications, certifications, and fellowship training in a like specialty that is at least equal to that of the treating provider who is requesting preauthorization of surgery or inpatient treatment.

(j) Insurers shall, on an annual basis, electronically submit their Peer Review Physician Profiles to the Commission at the following electronic site (ftp://ftp.ic.nc.gov) by July 1 of each year.
(k) All requests for preauthorization by health care providers, claimant's attorneys, or unrepresented claimants, and all preauthorization determinations made by insurers on the preauthorization requests shall be submitted on Industrial Commission Form 25PR. The Preauthorization Agent is responsible for providing the preauthorization review (PR) claim number and for forwarding medical records, communications, and preauthorization review determinations to the proper entities upon receipt, unless the insurer's Preauthorization Plan designates and identifies another person to perform this requirement.
(l) The failure of an insurer to make a determination on a request for preauthorization within seven business days as specified in G.S. 97-25.3 shall result in an automatic waiver of the insurer's right to contest the requested treatment, unless:

(1) an extension of time, not to exceed seven business days, is agreed upon by the insurer and the medical provider requesting preauthorization (or the claimant's attorney or unrepresented claimant, if no medical provider has requested preauthorization); or
(2) an additional extension of time is granted by the Commission pursuant to G.S. 97-25.3(a)(3).

(m) Requests made to the Commission for an extension of time shall be directed to the Office of the Executive Secretary, and shall be simultaneously copied to the requesting health care provider, if any, and to the claimant's attorney or to the claimant, if unrepresented.
(n) In accordance with G.S. 97-18(i), insurers are obligated to pay for any surgery or inpatient treatment provided under G.S. 97-25.3, for which preauthorization was requested for an admitted condition after the right to contest the preauthorization request is waived.

History Note: *Authority G.S. 97-25.3; 97-80(a);*
Eff. November 1, 2014.