304.17A-716 Prohibition against denial or reduction of payment for covered health benefit -- Conditions.

(1) No insurer or any other person providing or administering a health benefit plan shall deny or reduce payment for a service, procedure, treatment, drug, or device covered under the covered person's health benefit plan if:

(a) The covered person's provider, during normal business hours, contacts the insurer or the insurer's designee or agent on the day the covered person is expected to be discharged to request review of the covered person's continued hospitalization and the insurer, designee, or agent fails to provide a utilization review decision within twenty-four (24) hours of the request and prior to the time upon which any previous authorization will expire; or

(b) 1. The covered person's provider makes at least three (3) documented attempts during a four (4) consecutive hour period to contact the insurer, designee, or agent during normal business hours to request:

a. Review of a continued hospital stay;

b. Preauthorization of treatment for a covered person who is already hospitalized; or

c. Retrospective review of an emergency hospital admission where the covered person remains hospitalized at the time the review requested is made; and

2. The insurer, designee, or private review agent fails to be accessible via a toll-free telephone line for forty (40) hours per week during normal business hours.

(2) The insurer's liability to pay for the covered person's hospitalization under the circumstances set forth in subsection (1) of this section shall extend until the insurer, designee, or private review agent issues a utilization review decision on a request for review of the matters addressed under subsection (1)(b) of this section.

(3) The insurer's liability to pay under this section shall be conditioned on:

(a) The provider establishing verifiable documentation of the contact with, and subsequent failure of the insurer, designee, or agent to make the utilization review decision as set forth in subsection (1)(a) of this section; or

(b) The provider establishing verifiable documentation of the attempt to make contact with the insurer, designee, or agent as addressed in subsection (1)(b) of this section.

(4) In either instance, the contact or attempts to contact, as set forth in this section, shall be made by the means required by the insurer, designee, or agent for requesting utilization review.

(5) This section applies only when the request for review concerns covered health benefits, and it shall not supersede any limitations or exclusions in the covered person's health benefit plan. This section shall not apply if, in requesting a review, the provider does not furnish the information requested by the insurer or agent to make a utilization review decision or if actions by the provider

impede an insurer's or private review agent's ability to issue a utilization review decision.

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