

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

3

HOUSE BILL 1537*
Committee Substitute Favorable 6/21/00
Committee Substitute #2 Favorable 6/22/00

Short Title: Prompt Pay/External Review.

(Public)

Sponsors:

Referred to:

May 16, 2000

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS UNDER
3 HEALTH ACT TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS
4 UNDER HEALTH BENEFIT PLANS, TO MAKE CONFORMING
5 AMENDMENTS TO RELATED CLAIM PAYMENT LAWS, TO PROVIDE
6 STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF
7 EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND
8 MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE
9 OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH BENEFIT
10 PLAN COVERAGE DECISION MADE BY THE INSURER OR MANAGED
11 CARE PLAN; AND TO MAKE CONFORMING AMENDMENTS TO EXISTING
12 LAWS ON UTILIZATION REVIEW AND GRIEVANCES.

13 The General Assembly of North Carolina enacts:

14 **PART I. PROMPT PAY.**

15 Section 1. Article 3 of Chapter 58 of the General Statutes is amended by
16 adding new sections to read:

17 "**§ 58-3-225. Prompt claim payments under health benefit plans.**

18 (a) As used in this section:

- 1 (1) 'Health benefit plan' means an accident and health insurance policy or
2 certificate; a nonprofit hospital or medical service corporation contract;
3 a health maintenance organization subscriber contract; a plan provided
4 by a multiple employer welfare arrangement; or a plan provided by
5 another benefit arrangement, to the extent permitted by the Employee
6 Retirement Income Security Act of 1974, as amended, or by any waiver
7 of or other exception to that act provided under federal law or
8 regulation. 'Health benefit plan' does not mean any plan implemented or
9 administered by the North Carolina or United States Department of
10 Health and Human Services, or any successor agency, or its
11 representatives. 'Health benefit plan' also does not mean any of the
12 following kinds of insurance:
- 13 a. Credit.
 - 14 b. Disability income.
 - 15 c. Coverage issued as a supplement to liability insurance.
 - 16 d. Hospital income or indemnity.
 - 17 e. Insurance under which benefits are payable with or without
18 regard to fault and that is statutorily required to be contained in
19 any liability policy or equivalent self-insurance.
 - 20 f. Long-term or nursing home care.
 - 21 g. Medical payments under motor vehicle or homeowners'
22 insurance policies.
 - 23 h. Medicare supplement.
 - 24 i. Short-term limited duration health insurance policies as defined
25 in Part 144 of Title 45 of the Code of Federal Regulations.
 - 26 j. Workers' compensation.
- 27 (2) 'Claimant' includes a health care provider or facility that is responsible
28 under contract with the insurer or by valid assignment of benefits for
29 directly making the claim with an insurer, an insured, or an insured's
30 legal representative.
- 31 (3) 'Health care facility' means a facility that is licensed under Chapter
32 131E or Chapter 122C of the General Statutes or is owned or operated
33 by the State of North Carolina in which health care services are
34 provided to patients.
- 35 (4) 'Health care provider' means an individual who is licensed, certified, or
36 otherwise authorized under Chapter 90 of the General Statutes to
37 provide health care services in the ordinary course of business or
38 practice of a profession or in an approved education or training
39 program.
- 40 (5) 'Insurer' includes an insurance company subject to this Chapter, a
41 service corporation organized under Article 65 of this Chapter, a health
42 maintenance organization organized under Article 67 of this Chapter, or

1 a multiple employer welfare arrangement subject to Article 49 of this
2 Chapter, that writes a health benefit plan.

3 (b) An insurer shall, within 30 days after receipt of a claim, send by electronic or
4 paper mail to the claimant:

5 (1) Payment of the claim.

6 (2) Notice of denial of the claim.

7 (3) Notice that the proof of loss is inadequate or incomplete, or

8 (4) Notice that the claim is not submitted on the form required by the health
9 benefit plan, by the contract between the insurer and health care
10 provider or health care facility, or by applicable law.

11 (5) Notice that coordination of benefits information is needed in order to
12 pay the claim.

13 (6) Notice that the claim is pending based on nonpayment of fees or
14 premiums.

15 For purposes of this section, an insurer is presumed to have received a written claim five
16 business days after the claim has been placed first-class postage prepaid in the United
17 States mail and an electronic claim on the day the claim is electronically transmitted.

18 (c) If the claim is denied, the notice shall include the specific good faith reason or
19 reasons for the denial, including, without limitation, coordination of benefits, lack of
20 eligibility, or lack of coverage for the services provided. If the claim is contested or
21 cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending
22 receipt of requested coordination of benefits information, the notice shall contain the
23 specific good faith reason or reasons why the claim has not been paid and an itemization
24 or description of all of the information needed by the insurer to complete the processing
25 of the claim. If all or part of the claim is contested or cannot be paid because of the
26 application of a specific utilization management or medical necessity standard is not
27 satisfied, the notice shall contain that utilization management or medical necessity
28 standard. If the claim is contested or cannot be paid because of nonpayment of
29 premiums, the notice shall contain a statement advising the claimant of the nonpayment
30 of premiums. If a claim is not paid pending receipt of requested coordination of benefits
31 information, the notice shall so specify. If a claim is denied or contested in part, the
32 insurer shall pay the undisputed portion of the claim within 30 days after receipt of the
33 claim and send the notice of the denial or contested status within 30 days after receipt of
34 the claim. If a claim is contested or cannot be paid because the claim was not submitted
35 on the required form, the notice shall contain the required form, if the form is other than a
36 UB or HCFA form, and instructions to complete that form. Upon receipt of additional
37 information requested in its notice to the claimant, the insurer shall continue processing
38 the claim and pay or deny the claim within 30 days after receiving the additional
39 information.

40 (d) If an insurer requests additional information under subsection (c) of this
41 section and the insurer does not receive the additional information within 90 days after
42 the request was made, the insurer shall deny the claim and send the notice of denial to the
43 claimant in accordance with subsection (c) of this section. The insurer shall include the

1 specific reason or reasons for denial in the notice, including the fact that information that
2 was requested was not provided. The insurer shall inform the claimant in the notice that
3 the claim will be reopened if the information previously requested is submitted to the
4 insurer within one year after the date of the denial notice closing the claim.

5 (e) In order to facilitate submission of complete claims by providers, insurers shall
6 provide to providers treatment codes and payments applicable to each treatment code
7 used by the insurer to process claims.

8 (f) Health benefit plan claim payments that are not made in accordance with this
9 section shall bear interest at the rate of one and one half (1.5%) percent per month,
10 compounded daily, beginning on the date on which the claim should have been paid. If
11 additional information was requested by the insurer under subsection (b) of this section,
12 interest on health benefit claim payments shall begin to accrue on the 31st day after the
13 insurer received the additional information. A payment is considered made on the date
14 upon which a check, draft, or other valid negotiable instrument is placed in the United
15 States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the
16 date of the electronic transfer or other delivery of the payment to the claimant. This
17 subsection does not apply to claims for benefits that are not covered by the health benefit
18 plan; nor does this subsection apply to deductibles, co-payments, or other amounts for
19 which the insurer is not liable.

20 (g) Insurers may require that claims be submitted not less than 180 days after the
21 date of the provision of care to the patient by the health care provider and, in the case of
22 health care provider facility claims, not less than 180 days after the date of the patient's
23 discharge from the facility. Unless otherwise agreed to by the insurer and the claimant,
24 failure to submit a claim within the time required does not invalidate or reduce any claim
25 if it was not reasonably possible for the claimant to file the claim within that time,
26 provided that the claim is submitted as soon as reasonably possible and in no event,
27 except in the absence of legal capacity of the insured, later than one year from the time
28 submittal of the claim is otherwise required.

29 (h) If a claim for which the claimant is a health care provider or health care facility
30 has not been paid within 60 days after receipt of the initial claim, the insurer shall send a
31 claim status report to the insured. Provided, however, that the claims status report is not
32 required during the time an insurer is awaiting information requested under subsection (c)
33 of this section. The report shall indicate that the claim is under review and the insurer is
34 communicating with the health care provider or health care facility to resolve the matter.
35 While a claim remains unresolved, the insurer shall send a claim status report to the
36 insured every 30 days after the previous report was sent.

37 (i) To the extent permitted by the contract between the insurer and the health care
38 provider or health care facility, the insurer may recover overpayments made to the health
39 care provider or health care facility by making demands for refunds and by offsetting
40 future payments. Any such recoveries may also include related interest payments that
41 were made under the requirements of this section. Recoveries by the insurer must be
42 accompanied by the specific reason and adequate information to identify the specific
43 claim. To the extent permitted by the contract between the insurer and the health care

1 provider or health care facility, the health care provider or health care facility may
2 recover underpayments or nonpayments by the insurer by making demands for refunds.
3 Any such recoveries by the health care provider or health care facility of underpayments
4 or nonpayment by the insurer may include applicable interest under this section. The
5 period for which such recoveries may be made may be specified in the contract between
6 the insurer and health care provider or health care facility.

7 (j) Every insurer shall maintain records of its activities under this section,
8 including records of when each claim was received, paid, denied, or pending, and the
9 insurer's review and handling of each claim under this section, as well as documentation
10 sufficient to demonstrate compliance with this section.

11 (k) A violation of this section by an insurer subjects the insurer to the sanctions in
12 G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair
13 the right of a claimant to pursue any other action or remedy available under law.

14 (l) An insurer is not in violation of this section nor subject to interest payments
15 under this section if its failure to comply with this section is caused in material part by (i)
16 the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control,
17 including an act of God, insurrection, strike, fire, or power outages. In addition, an
18 insurer is not in violation of this section or subject to interest payments to the claimant
19 under this section if the insurer has a reasonable basis to believe that the claim was
20 submitted fraudulently and notifies the claimant of the alleged fraud.

21 (m) This section does not apply to claims processed by an insurer on claims
22 adjudication software that was implemented prior to January 1, 1982, provided that the
23 insurer:

24 (1) Verifies with the Commissioner that its claims adjudication software
25 complies with this subsection; and

26 (2) Is implementing a new claims adjudication software system and is
27 proceeding in good faith to move all claims to the new system as soon
28 as possible and in any event no later than December 31, 2002.

29 This subsection expires January 1, 2003.

30 (n) The Commissioner shall adopt rules to implement this section.

31 **"§ 58-3-226. Reports on prompt processing.**

32 (a) As used in this section, the terms 'insurer' and 'claimant' have the meaning
33 applied in G.S. 58-3-225.

34 (b) An insurer shall file with the Commissioner quarterly reports that contain all of
35 the following:

36 (1) The number and percentage of total claims received by the insurer
37 during the prior quarter.

38 (2) The number and percentage of claims processed in which the claimant
39 was required to submit additional information to facilitate processing.

40 (3) The number and percentage of claims in which the claimant was
41 notified that proof of loss was inadequate or incomplete, or notified that
42 the claim was not submitted on the required form.

1 (4) The value and percentage of total claims paid within 30 calendar days of
2 receipt of the claim.

3 (5) The value and percentage of total claims in which the undisputed
4 portion was paid within 30 days of receipt of the claim.

5 (6) The number and percentage of total claims that were denied because the
6 insurer did not receive additional information within 90 days after the
7 request for additional information was made.

8 (7) The number and percentage of total claims paid within 30 calendar days
9 of receipt of additional information from the claimant.

10 (8) The total dollar amount of penalties and interest paid by the insurer
11 pursuant to G.S. 58-3-225.

12 (c) An insurer shall file the reports required by this section on or before the first
13 day of each quarter. The Commissioner shall make the reports available for public
14 inspection immediately upon receipt of the report."

15 Section 2. G.S. 58-3-100(c) reads as rewritten:

16 "(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO,
17 service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after
18 receiving written notice of the claim, but only if the notice contains sufficient information
19 for the insurer to identify the specific coverage involved. Acknowledgement of the claim
20 shall be made to the claimant or his legal representative advising that the claim is being
21 investigated; or shall be a payment of the claim; or shall be a bona fide written offer of
22 settlement; or shall be a written denial of the claim. A claimant includes an insured, a
23 health care provider, or a health care facility that is responsible for directly making the
24 claim with an insurer. This subsection does not apply to insurers subject to G.S. 58-3-
25 225."

26 Section 3. G.S. 58-51-15(a)(7) reads as rewritten:

27 "(7) A provision in the substance of the following language:

28 PROOFS OF LOSS: Written proof of loss must be furnished to the
29 insurer at its said office in the case of a claim for loss for which this
30 policy provides any periodic payment contingent upon continuing loss
31 within ~~90-180~~ days after the termination of the period for which the
32 insurer is liable and in case of a claim for any other loss within ~~90-180~~
33 days after the date of such loss. Failure to furnish such proof within the
34 time required shall not invalidate nor reduce any claim if it was not
35 reasonably possible to give proof within such time, provided such proof
36 is furnished as soon as reasonably possible and in no event, except in
37 the absence of legal ~~capacity, capacity of the insured,~~ later than one year
38 from the time proof is otherwise required."

40 **PART II. EXTERNAL REVIEW/MANAGED CARE.**

41 Section 4. The title of Article 50 of Chapter 58 of the General Statutes reads as
42 rewritten:

43 **"ARTICLE 50.**

GENERAL ACCIDENT AND HEALTH INSURANCE REGULATIONS."

Section 5. Article 50 of Chapter 58 of the General Statutes is amended as follows:

- (1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."
- (2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."
- (3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."
- (4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."
- (5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

Section 6. G.S. 58-50-151 is recodified as G.S. 58-51-116.

Section 7. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:"

Section 8. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"PART 4. HEALTH BENEFIT PLAN EXTERNAL REVIEW.**"§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of a noncertification decision, an appeal decision upholding a noncertification, or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

- (1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.
- (2) 'Disclose' means to release, transfer, or otherwise divulge protected health information to any person other than the individual's health care provider or the individual who is the subject of the protected health information or the individual's legal guardian, including the custodial parent(s) of a minor child.
- (3) 'Health information' means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to: the past, present, or future physical, mental, or behavioral health or condition of an individual or a

1 member of the individual's family; the provision of health care services
2 to an individual; or payment for the provision of health care services to
3 an individual.

4 (4) 'Independent review organization' or 'organization' means an entity that
5 conducts independent external reviews of appeals of noncertifications
6 and second-level grievance review decisions.

7 (5) 'Protected health information' means health information that directly
8 identifies an individual who is the subject of the information; or with
9 respect to which there is a reasonable basis to believe that the
10 information could be used to directly identify an individual.

11 (6) 'Valid authorization' means an authorization obtained from an
12 individual or the individual's legal guardian, including a custodial parent
13 of a minor child in writing, electronic, or other form that indicates the
14 individual's consent to the disclosure of protected health information for
15 the purposes set out in G.S. 58-50-77(e).

16 "§ 58-50-76: Reserved for future codification.

17 "§ 58-50-77. Notice of right to external review.

18 (a) An insurer shall notify the covered person in writing of the covered person's
19 right to request an external review and include the appropriate statements and information
20 set forth in this section at the time the insurer sends written notice of:

21 (1) A noncertification decision;

22 (2) An appeal decision under G.S. 58-50-61 upholding a noncertification;
23 and

24 (3) A second-level grievance review decision under G.S. 58-50-62
25 upholding the original noncertification.

26 (b) The insurer shall include in the notice required under subsection (a) of this
27 section:

28 (1) For a notice related to a noncertification decision, a statement informing
29 the covered person that if the covered person has a medical condition
30 where the time frame for completion of an expedited appeal decision
31 under G.S. 58-50-61(1) would reasonably appear to seriously jeopardize
32 the life or health of the covered person or jeopardize the covered
33 person's ability to regain maximum function, the covered person may
34 file a request for an expedited external review under G.S. 58-50-82 at
35 the same time the covered person files a request for an expedited appeal
36 under G.S. 58-50-61(1), but that the organization assigned to conduct the
37 expedited external review will determine whether the covered person
38 shall be required to complete the expedited appeal before conducting the
39 expedited external review;

40 (2) For a notice related to an appeal decision upholding a noncertification
41 under G.S. 58-50-61, a statement informing the covered person that if
42 the covered person has a medical condition where the time frame for
43 completion of an expedited second-level grievance review under G.S.

1 58-50-62(i) would reasonably appear to seriously jeopardize the life or
2 health of the covered person or jeopardize the covered person's ability to
3 regain maximum function, the covered person may file a request for an
4 expedited external review under G.S. 58-50-82 at the same time the
5 covered person files a request for an expedited second-level grievance
6 review under G.S. 58-50-62(i), but that the organization assigned to
7 conduct the expedited external review will determine whether the
8 covered person shall be required to complete the expedited second-level
9 grievance review before conducting the expedited external review;

10 (3) For a notice related to a final second-level grievance review decision
11 under G.S. 58-50-62, a statement informing the covered person that if
12 the covered person has a medical condition where the time frame for
13 completion of a standard external review under G.S. 58-50-80 would
14 reasonably appear to seriously jeopardize the life or health of the
15 covered person or jeopardize the covered person's ability to regain
16 maximum function, the covered person may file a request for an
17 expedited external review under G.S. 58-50-82; and

18 (4) For a noncertification that concerns an admission, availability of care,
19 continued stay, or health care service for which the covered person
20 received emergency services, but has not been discharged from a
21 facility, a statement informing the covered person that the covered
22 person may request an expedited external review under G.S. 58-50-82.

23 (c) The covered person may file a grievance under the insurer's internal grievance
24 process under G.S. 58-50-61 and G.S. 58-50-62, but if the insurer has not issued a written
25 decision to the covered person within 45 days after the date the covered person files the
26 grievance with the insurer and the covered person has not requested or agreed to a delay,
27 the covered person may file a request for external review under G.S. 58-50-80 of this
28 section and shall be considered to have exhausted the insurer's internal grievance process
29 for purposes of G.S. 58-50-79.

30 (d) In addition to the information to be provided under subsections (a) and (b) of
31 this section, the insurer shall include a copy of the description of both the standard and
32 expedited external review procedures the insurer is required to provide under G.S. 58-50-
33 93, including the provisions in the external review procedures that give the covered
34 person the opportunity to submit additional information.

35 (e) An insurer, agent, or contractor that has collected protected health information
36 under a valid authorization under this Part may use and disclose the protected health
37 information to a person acting on behalf of or at the direction of the insurer for the
38 performance of the insurer's insurance functions: claims administration, claims
39 adjustment and management, securing payment, assuring the delivery of health care,
40 fraud investigation, underwriting, loss control, rate-making functions, reinsurance, risk
41 management, case management, disease management, quality assessment, quality
42 improvement, provider credentialing verification, utilization review, peer review
43 activities, grievance procedures, policyholder service functions, and internal

1 administration of compliance, managerial, and information systems. Additional
2 insurance functions may be allowed for the purpose of this subsection with the prior
3 approval of the Commissioner. The protected health information shall not be used or
4 disclosed for any purpose other than those described in this subsection.

5 (f) Except for a request for an expedited external review under G.S. 58-50-82, all
6 requests for external review shall be made in writing to the Commissioner.

7 "§ 58-50-78: Reserved for future codification.

8 "§ 58-50-79. Exhaustion of internal grievance process.

9 (a) Except as provided in subsections (d) through (g) of this section, a request for
10 an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the
11 covered person has exhausted the insurer's internal grievance process under G.S. 58-50-
12 61 and G.S. 58-50-62.

13 (b) A covered person shall be considered to have exhausted the insurer's internal
14 grievance process for purposes of this section, if the covered person:

15 (1) Has filed a second-level grievance involving a noncertification appeal
16 decision under G.S. 58-50-62; and

17 (2) Except to the extent the covered person requested or agreed to a delay,
18 has not received a written decision on the grievance from the insurer
19 within 45 days since the date the covered person filed the grievance
20 with the insurer.

21 (c) Notwithstanding subsection (b) of this section, a covered person may not make
22 a request for an external review of a noncertification involving a retrospective review
23 determination made under G.S. 58-50-61 until the covered person has exhausted the
24 insurer's internal grievance process.

25 (d) At the same time a covered person files a request for an expedited appeal
26 involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file a
27 request for an expedited external review of the noncertification under G.S. 58-50-82 if
28 the covered person has a medical condition where the time frame for completion of an
29 expedited appeal involving a noncertification set forth in G.S. 58-50-61(l) would
30 reasonably appear to seriously jeopardize the life or health of the covered person or
31 jeopardize the covered person's ability to regain maximum function. An insurer may
32 waive its right to conduct an expedited appeal and allow the covered person to proceed
33 with an expedited external review of the noncertification.

34 (e) Upon receipt of a request for an expedited external review under subsection (d)
35 of this section, the organization conducting the external review in accordance with the
36 provisions of G.S. 58-50-82 shall immediately determine whether the covered person
37 shall be required to complete the expedited appeal set forth in G.S. 58-50-61(l) before it
38 conducts the expedited external review, unless the insurer has waived its right to conduct
39 an expedited review of the appeal decision.

40 (f) Upon a determination made under subsection (e) of this section that the
41 covered person must first complete the expedited appeal process under G.S. 58-50-61(l),
42 the organization immediately shall notify the covered person and the insurer of this
43 determination and that it will not proceed with the expedited external review under G.S.

1 58-50-82 until completion of the expedited appeal process and the covered person's
2 grievance at the completion of the expedited appeal process remains unresolved.

3 (g) A request for an external review of a noncertification may be made before the
4 covered person has exhausted the insurer's internal grievance procedures under G.S. 58-
5 50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion
6 requirement.

7 (h) If the requirement to exhaust the insurer's internal grievance procedures is
8 waived under subsection (g) of this section, the covered person may file a request in
9 writing for a standard external review as set forth in G.S. 58-50-80.

10 **"§ 58-50-80. Standard external review.**

11 (a) Within 60 days after the date of receipt of a notice of a noncertification appeal
12 decision or a second-level grievance review decision under G.S. 58-50-77, a covered
13 person may file a request for an external review with the Commissioner.

14 (b) Upon receipt of a request for an external review under subsection (a) of this
15 section, the Commissioner immediately shall notify and send a copy of the request to the
16 insurer that made the decision which is the subject of the request. The insurer shall
17 immediately submit to the Commissioner the information required for the preliminary
18 review under subsection (c) of this section.

19 (c) Within five business days after the date of receipt of a request for an external
20 review, the Commissioner shall complete a preliminary review of the request to
21 determine whether:

22 (1) The individual is or was a covered person in the health benefit plan at
23 the time the health care service was requested or, in the case of a
24 retrospective review, was a covered person in the health benefit plan at
25 the time the health care service was provided.

26 (2) The health care service that is the subject of the noncertification appeal
27 decision or the second-level grievance review decision upholding a
28 noncertification reasonably appears to be a covered service under the
29 covered person's health benefit plan.

30 (3) The covered person has exhausted the insurer's internal grievance
31 process under G.S. 58-50-62(i) unless the covered person is not
32 required to exhaust the insurer's internal grievance process under G.S.
33 58-50-79.

34 (4) The covered person has provided all the information and forms required
35 by the Commissioner that are necessary to process an external review,
36 including the authorization form provided under G.S. 58-50-77(e).

37 (d) Upon completion of the preliminary review under subsection (c) of this
38 section, the Commissioner immediately shall notify the covered person in writing
39 whether the request is complete and whether the request has been accepted for external
40 review.

41 (e) If the request is accepted for external review, the Commissioner shall:

42 (1) Include in the notice provided under subsection (d) of this section a
43 statement that the covered person may submit to the Commissioner in

1 writing within seven days after the date of the notice additional
2 information and supporting documentation that the organization shall
3 consider when conducting the external review.

4 (2) Immediately notify the insurer in writing of the acceptance of the
5 request for external review.

6 (3) Provide the covered person and the covered person's provider with a list
7 of organizations approved under G.S. 58-50-85.

8 (4) Inform the covered person that the covered person has the right to select
9 the organization of his or her choice and notify the Commissioner
10 within five days after receipt of the notice, and that if the covered
11 person does not select an organization and inform the Commissioner of
12 the selection within five days after receipt of the notice, the
13 Commissioner will assign an organization to conduct the external
14 review.

15 (f) If the request is not complete, the Commissioner shall request from the covered
16 person the information or materials needed to make the request complete. The covered
17 person shall furnish the Commissioner with the requested information or materials within
18 90 days after the date of the insurer's decision for which external review is requested. If
19 the request is not accepted for external review, the Commissioner shall inform the
20 covered person and the insurer in writing of the reasons for its nonacceptance.

21 (g) If the insured does not select an organization of his or her choice and notify the
22 Commissioner of the selection within five days after receipt of the Commissioner's notice
23 under subsection (e) of this section, the Commissioner shall systematically assign an
24 appropriate independent review organization that has been approved under G.S. 58-50-85
25 to conduct the external review. In reaching a decision, the assigned organization is not
26 bound by any decisions or conclusions reached during the insurer's utilization review
27 process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-
28 62.

29 (h) Within seven days after the date of receipt of the notice provided under
30 subsection (e) of this section, the insurer or its designee utilization review organization
31 shall provide to the assigned organization the documents and any information considered
32 in making the noncertification appeal decision or the second-level grievance review
33 decision. Except as provided in subsection (i) of this section, failure by the insurer or its
34 designee utilization review organization to provide the documents and information within
35 the time specified in this subsection shall not delay the conduct of the external review.

36 (i) If the insurer or its utilization review organization fails to provide the
37 documents and information within the time specified in subsection (h) of this section, the
38 assigned organization may terminate the external review and make a decision to reverse
39 the noncertification appeal decision or the second-level grievance review decision.
40 Immediately upon making the decision under this subsection, the organization shall
41 notify the covered person, the insurer, and the Commissioner.

42 (j) The assigned organization shall review all of the information and documents
43 received under subsections (h) and (i) of this section and any other information submitted

1 in writing by the covered person under subsection (e) of this section that has been
2 forwarded to the organization by the Commissioner. Upon receipt of any information
3 submitted by the covered person under subsection (e) of this section, at the same time the
4 Commissioner forwards the information to the organization, the Commissioner shall
5 forward the information to the insurer.

6 (k) Upon receipt of the information required to be forwarded under subsection (j)
7 of this section, the insurer may reconsider its noncertification appeal decision or second-
8 level grievance review decision that is the subject of the external review. Reconsideration
9 by the insurer of its noncertification appeal decision or second-level grievance review
10 decision under this subsection shall not delay or terminate the external review. The
11 external review shall be terminated if the insurer decides, upon completion of its
12 reconsideration, to reverse its noncertification appeal decision or second-level grievance
13 review decision and provide coverage or payment for the requested health care service
14 that is the subject of the noncertification appeal decision or second-level grievance
15 review decision.

16 (l) Immediately upon making the decision to reverse its noncertification appeal
17 decision or second-level grievance review decision under subsection (k) of this section,
18 the insurer shall notify the covered person, the organization, and the Commissioner in
19 writing of its decision. The organization shall terminate the external review upon receipt
20 of the notice from the insurer sent under this subsection.

21 (m) In addition to the documents and information provided under subsections (h)
22 and (i) of this section, the assigned organization, to the extent the documents or
23 information are available and the organization considers them appropriate, shall consider
24 the following in reaching a decision:

25 (1) The covered person's medical records.

26 (2) The attending health care provider's recommendation.

27 (3) Consulting reports from appropriate health care providers and other
28 documents submitted by the insurer, covered person, or the covered
29 person's treating provider.

30 (4) The terms of coverage under the covered person's health benefit plan
31 with the insurer to ensure that the organization's decision shall not be
32 contrary to the terms of coverage under the covered person's health
33 benefit plan with the insurer.

34 (5) The most appropriate practice guidelines, which may include generally
35 accepted practice guidelines, evidence-based practice guidelines, or any
36 other practice guidelines developed by the federal government, national
37 or professional medical societies, boards, and associations. Local
38 practice guidelines may be used when appropriate.

39 (6) Any applicable clinical review criteria developed and used by the
40 insurer or its designee utilization review organization.

41 (7) Medical necessity, as defined in G.S. 58-3-200(b).

42 (n) Within 45 days after the date of receipt by the Commissioner of the request for
43 external review, the assigned organization shall provide written notice of its decision to

1 uphold or reverse the noncertification appeal decision or second-level grievance review
2 decision to the covered person, the insurer, and the Commissioner.

3 (o) The organization shall include in the notice sent under subsection (n) of this
4 section:

5 (1) A general description of the reason for the request for external review.

6 (2) The date the organization received the assignment from the
7 Commissioner to conduct the external review.

8 (3) The date the organization received information and documents
9 submitted by the covered person and by the insurer.

10 (4) The date the external review was conducted.

11 (5) The date of its decision.

12 (6) The principal reason or reasons for its decision.

13 (7) The clinical rationale for its decision.

14 (8) References to the evidence or documentation, including the practice
15 guidelines, considered in reaching its decision.

16 (9) The professional qualifications and licensure of the clinical peer
17 reviewers.

18 (10) Notice to the covered person that he or she is not liable for the cost of
19 the external review.

20 (p) Upon receipt of a notice of a decision under subsection (n) of this section
21 reversing the noncertification appeal decision or second-level grievance review decision,
22 the insurer immediately shall approve the coverage that was the subject of the
23 noncertification appeal decision or second-level grievance review decision.

24 **"§ 58-50-81: Reserved for future codification.**

25 **"§ 58-50-82. Expedited external review.**

26 (a) Except as provided in subsection (h) of this section, a covered person may
27 make a request for an expedited external review with the Commissioner at the time the
28 covered person receives:

29 (1) A noncertification decision where:

30 a. The covered person has a medical condition for which the time
31 frame for completion of an expedited appeal under G.S. 58-50-
32 61(l) would reasonably appear to seriously jeopardize the life or
33 health of the covered person or jeopardize the covered person's
34 ability to regain maximum function; and

35 b. The covered person has filed a request for an expedited appeal of
36 a noncertification as set forth in G.S. 58-50-61(l); or

37 (2) An appeal decision upholding a noncertification where:

38 a. The covered person has a medical condition for which the time
39 frame for completion of an expedited second-level grievance
40 review of a noncertification set forth in G.S. 58-50-62(i) would
41 reasonably appear to seriously jeopardize the life or health of the
42 covered person or jeopardize the covered person's ability to
43 regain maximum function; and

1 b. The covered person has filed a request for an expedited second-
2 level grievance review under G.S. 58-50-62(i); or

3 (3) A second-level grievance review decision upholding a noncertification
4 under G.S. 58-50-62(h) or (i) where the covered person has a medical
5 condition where the time frame for completion of a standard external
6 review under G.S. 58-50-80 would reasonably appear to seriously
7 jeopardize the life or health of the covered person or jeopardize the
8 covered person's ability to regain maximum function; or

9 (4) A noncertification decision that involves an admission, availability of
10 care, continued stay, or health care service for which the covered person
11 received emergency services, but has not been discharged from a
12 facility.

13 (b) At the time the Commissioner receives a request for an expedited external
14 review, the Commissioner immediately shall:

15 (1) Notify and provide a copy of the request to the insurer that made the
16 noncertification decision, the appeal decision involving a
17 noncertification, or the second-level grievance review decision which is
18 the subject of the request.

19 (2) For a request that the Commissioner has determined meets the
20 reviewability requirements set forth in G.S. 58-50-80(c), assign an
21 organization that has been approved under G.S. 58-50-87. The
22 organization shall immediately determine whether the request should be
23 reviewed on an expedited basis because the time frame for completion
24 of a standard external review under G.S. 58-50-80 would seriously
25 jeopardize the life or health of the covered person or would jeopardize
26 the covered person's ability to regain maximum function. The
27 organization shall then inform the covered person, insurer, and
28 Commissioner of its determination and conduct a review and make a
29 decision on the review within the appropriate time frame.

30 (c) In reaching a decision, the assigned organization is not bound by any decisions
31 or conclusions reached during the insurer's utilization review process or internal
32 grievance process under G.S. 58-50-61 and G.S. 58-50-62.

33 (d) At the time the insurer receives the notice under subsection (b) of this section,
34 the insurer or its designee utilization review organization shall immediately provide or
35 transmit all necessary documents and information considered in making the final
36 noncertification decision to the assigned organization electronically or by telephone or
37 facsimile or any other available expeditious method.

38 (e) In addition to the documents and information provided or transmitted under
39 subsection (d) of this section, the assigned organization, to the extent the information or
40 documents are available and the organization considers them appropriate, shall consider
41 the following in reaching a decision:

42 (1) The covered person's pertinent medical records.

43 (2) The attending health care provider's recommendation.

1 (3) Consulting reports from appropriate health care providers and other
2 documents submitted by the insurer, covered person, or the covered
3 person's treating provider.

4 (4) The terms of coverage under the covered person's health benefit plan
5 with the insurer to ensure that the organization's decision shall not be
6 contrary to the terms of coverage under the covered person's health
7 benefit plan with the insurer.

8 (5) The most appropriate practice guidelines, which may include generally
9 accepted practice guidelines, evidence-based practice guidelines, or any
10 other practice guidelines developed by the federal government, national
11 or professional medical societies, boards, and associations. Local
12 practice guidelines may be used when appropriate.

13 (6) Any applicable clinical review criteria developed and used by the
14 insurer or its designee utilization review organization in making
15 noncertification decisions.

16 (7) Medical necessity, as defined in G.S. 58-3-200(b).

17 (f) As expeditiously as the covered person's medical condition or circumstances
18 require, but not more than four days after the date of receipt of the request for an
19 expedited external review, the assigned organization shall make a decision to uphold or
20 reverse the noncertification appeal decision or second-level grievance review decision
21 and notify the covered person, the insurer, and the Commissioner of the decision.

22 (g) If the notice provided under subsection (f) of this section was not in writing,
23 within two days after the date of providing that notice, the assigned organization shall
24 provide written confirmation of the decision to the covered person, the insurer, and the
25 Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of
26 the notice, a decision under subsection (f) of this section reversing the noncertification
27 appeal decision or second-level grievance review decision, the insurer immediately shall
28 approve the coverage that was the subject of the noncertification.

29 (h) An expedited external review may not be provided for retrospective
30 noncertifications.

31 **"§ 58-50-83: Reserved for future codification.**

32 **"§ 58-50-84. Binding nature of external review decision.**

33 (a) An external review decision is binding on the insurer.

34 (b) An external review decision is binding on the covered person except to the
35 extent the covered person has other remedies available under applicable federal or State
36 law.

37 (c) A covered person may not file a subsequent request for external review
38 involving the same noncertification appeal decision or second-level grievance review
39 decision for which the covered person has already received an external review decision
40 under this Part.

41 **"§ 58-50-85. Approval of independent review organizations.**

42 (a) The Commissioner shall approve independent review organizations eligible to
43 be assigned to conduct external reviews under this Part to ensure that an organization

1 satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner
2 shall develop an application form for initially approving and for reapproving
3 organizations to conduct external reviews.

4 (b) Any organization wishing to be approved to conduct external reviews under
5 this Part shall submit the application form and include with the form all documentation
6 and information necessary for the Commissioner to determine if the organization satisfies
7 the minimum qualifications established under G.S. 58-50-87.

8 (c) The Commissioner may, in his discretion, determine that accreditation by a
9 nationally recognized private accrediting entity with established and maintained
10 standards for independent review organizations that meet the minimum qualifications
11 established under G.S. 58-50-87 will cause an independent review organization to be
12 deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-
13 87. A decision by the Commissioner to recognize an accreditation program for the
14 purpose of granting deemed status may be made only after reviewing the accreditation
15 standards and program information submitted by the accrediting body. An independent
16 review organization seeking deemed status due to its accreditation shall submit original
17 documentation issued by the accrediting body to demonstrate its accreditation.

18 (d) The Commissioner may charge an application fee that independent review
19 organizations shall submit to the Commissioner with an application for approval and
20 reapproval.

21 (e) An approval is effective for two years, unless the Commissioner determines
22 before expiration of the approval that the independent review organization is not
23 satisfying the minimum qualifications established under G.S. 58-50-87.

24 (f) Whenever the Commissioner determines that an independent review
25 organization no longer satisfies the minimum requirements established under G.S. 58-50-
26 87, the Commissioner shall terminate the approval of the independent review
27 organization and remove the independent review organization from the list of
28 independent review organizations approved to conduct external reviews under this Part
29 that is maintained by the Commissioner under subsection (g) of this section.

30 (g) The Commissioner shall maintain and periodically update a list of approved
31 independent review organizations.

32 **"§ 58-50-86: Reserved for future codification.**

33 **"§ 58-50-87. Minimum qualifications for independent review organizations.**

34 (a) As a condition of approval under G.S. 58-50-85 to conduct external reviews,
35 an independent review organization shall have and maintain written policies and
36 procedures that govern all aspects of both the standard external review process and the
37 expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that
38 include, at a minimum:

39 (1) A quality assurance mechanism in place that ensures:

40 a. That external reviews are conducted within the specified time
41 frames and required notices are provided in a timely manner.

- 1 **b.** The selection of qualified and impartial clinical peer reviewers to
2 conduct external reviews on behalf of the independent review
3 organization and suitable matching of reviewers to specific cases.
4 **c.** The confidentiality of medical and treatment records and clinical
5 review criteria.
6 **d.** That any person employed by or under contract with the
7 independent review organization adheres to the requirements of
8 this Part.
9 **(2)** A toll-free telephone service to receive information on a 24-hour-day,
10 seven-day-a-week basis related to external reviews that is capable of
11 accepting, recording, or providing appropriate instruction to incoming
12 telephone callers during other than normal business hours.
13 **(3)** Agreement to maintain and provide to the Commissioner the
14 information set out in G.S. 58-50-90.
15 **(4)** A program for credentialing clinical peer reviewers.
16 **(5)** Agreement to contractual terms or written requirements established by
17 the Commissioner regarding the procedures for handling a review.
18 **(b)** All clinical peer reviewers assigned by an independent review organization to
19 conduct external reviews shall be medical doctors or other appropriate health care
20 providers who meet the following minimum qualifications:
21 **(1)** Be an expert in the treatment of the covered person's injury, illness, or
22 medical condition that is the subject of the external review.
23 **(2)** Be knowledgeable about the recommended health care service or
24 treatment through recent or current actual clinical experience treating
25 patients with the same or similar injury, illness, or medical condition of
26 the covered person.
27 **(3)** If the covered person's treating provider is a medical doctor, hold a
28 nonrestricted license from the North Carolina Medical Board and, if a
29 specialist medical doctor, a current certification by a recognized
30 American medical specialty board in the area or areas appropriate to the
31 subject of the external review.
32 **(4)** If the covered person's treating provider is not a medical doctor, hold a
33 nonrestricted North Carolina license, registration, or certification in the
34 same allied health occupation as the covered person's treating provider.
35 **(5)** Have no history of disciplinary actions or sanctions, including loss of
36 staff privileges or participation restrictions, that have been taken or are
37 pending by any hospital, governmental agency or unit, or regulatory
38 body that raise a substantial question as to the clinical peer reviewer's
39 physical, mental, or professional competence or moral character.
40 **(c)** In addition to the requirements set forth in subsection (a) of this section, an
41 independent review organization may not own or control, be a subsidiary of or in any
42 way be owned or controlled by, or exercise control with a health benefit plan, a national,

1 State, or local trade association of health benefit plans, or a national, State, or local trade
2 association of health care providers.

3 (d) In addition to the requirements set forth in subsections (a), (b), and (c) of this
4 section, to be approved under G.S. 58-50-85 to conduct an external review of a specified
5 case, neither the independent review organization selected to conduct the external review
6 nor any clinical peer reviewer assigned by the independent organization to conduct the
7 external review may have a material professional, familial, or financial conflict of interest
8 with any of the following:

9 (1) The insurer that is the subject of the external review.

10 (2) The covered person whose treatment is the subject of the external
11 review or the covered person's authorized representative.

12 (3) Any officer, director, or management employee of the insurer that is the
13 subject of the external review.

14 (4) The health care provider, the health care provider's medical group, or
15 independent practice association recommending the health care service
16 or treatment that is the subject of the external review.

17 (5) The facility at which the recommended health care service or treatment
18 would be provided.

19 (6) The developer or manufacturer of the principal drug, device, procedure,
20 or other therapy being recommended for the covered person whose
21 treatment is the subject of the external review.

22 (e) In determining whether an independent review organization or a clinical peer
23 reviewer of the independent review organization has a material professional, familial, or
24 financial conflict of interest for purposes of subsection (d) of this section, the
25 Commissioner shall take into consideration situations where the independent review
26 organization to be assigned to conduct an external review of a specified case or a clinical
27 peer reviewer to be assigned by the independent review organization to conduct an
28 external review of a specified case may have an apparent professional, familial, or
29 financial relationship or connection with a person described in subsection (d) of this
30 section, but that the characteristics of that relationship or connection are such that they
31 are not a material professional, familial, or financial conflict of interest that results in the
32 disapproval of the independent review organization or the clinical peer reviewer from
33 conducting the external review.

34 **"§ 58-50-88: Reserved for future codification.**

35 **"§ 58-50-89. Hold harmless for independent review organizations.**

36 No independent review organization or clinical peer reviewer working on behalf of
37 an organization shall be liable in damages to any person for any opinions rendered during
38 or upon completion of an external review conducted under this Part, unless the opinion
39 was rendered in bad faith or involved gross negligence.

40 **"§ 58-50-90. External review reporting requirements.**

41 (a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an
42 external review shall maintain written records in the aggregate and by insurer on all
43 requests for external review for which it conducted an external review during a calendar

1 year and submit a report to the Commissioner, as required under subsection (b) of this
2 section.

3 (b) Each organization required to maintain written records on all requests for
4 external review under subsection (a) of this section for which it was assigned to conduct
5 an external review shall submit to the Commissioner, at least annually, a report in the
6 format specified by the Commissioner.

7 (c) The report shall include in the aggregate and for each insurer:

8 (1) The total number of requests for external review.

9 (2) The number of requests for external review resolved and, of those
10 resolved, the number resolved upholding the noncertification appeal
11 decision or second-level grievance review decision and the number
12 resolved reversing the noncertification appeal decision or second-level
13 grievance review decision.

14 (3) The average length of time for resolution.

15 (4) A summary of the types of coverages or cases for which an external
16 review was sought, as provided in the format required by the
17 Commissioner.

18 (5) The number of external reviews under G.S. 58-50-80(k) and (l) that
19 were terminated as the result of a reconsideration by the insurer of its
20 noncertification appeal decision or second-level grievance review
21 decision after the receipt of additional information from the covered
22 person.

23 (6) Any other information the Commissioner may request or require.

24 (d) The organization shall retain the written records required under this section for
25 at least three years.

26 (e) Each insurer shall maintain written records in the aggregate and for each type
27 of health benefit plan offered by the insurer on all requests for external review of which
28 the insurer receives notice from the Commissioner under this Part. The insurer shall
29 retain the written records required under this section for at least three years.

30 "§ 58-50-91: Reserved for future codification.

31 "§ 58-50-92. Funding of external review.

32 The insurer against which a request for a standard external review or an expedited
33 external review is filed shall reimburse the Department of Insurance for the fees charged
34 by the organization in conducting the external review.

35 "§ 58-50-93. Disclosure requirements.

36 (a) Each insurer shall include a description of the external review procedures in or
37 attached to the policy, certificate, membership booklet, outline of coverage, or other
38 evidence of coverage it provides to covered persons.

39 (b) The description required under subsection (a) of this section shall include a
40 statement that informs the covered person of the right of the covered person to file a
41 request for an external review of a noncertification appeal decision or a second-level
42 grievance review decision upholding a noncertification with the Commissioner. The
43 statement shall include the telephone number and address of the Commissioner.

1 (c) In addition to subsection (b) of this section, the statement shall inform the
2 covered person that, when filing a request for an external review, the covered person will
3 be required to authorize the release of any medical records of the covered person that
4 may be required to be reviewed for the purpose of reaching a decision on the external
5 review.

6 **"§ 58-50-94. Competitive selection of independent review organizations.**

7 (a) The Commissioner shall prepare and publish requests for proposals from
8 independent review organizations that want to be approved under G.S. 58-50-85. All
9 proposals shall be sealed. The Commissioner shall open all proposals in public.

10 (b) After the public opening, the Commissioner shall review the proposals,
11 examining the costs and quality of the services offered by the independent review
12 organizations, the reputation and capabilities of the independent review organizations
13 submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The
14 Commissioner shall determine which proposal or proposals would satisfy the provisions
15 of this Part. The Commissioner shall make his determination in consultation with an
16 evaluation committee whose membership includes representatives of insurers subject to
17 Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and
18 insureds. In selecting the review organizations, in addition to considering cost, quality,
19 and adherence to the requirements of the request for proposals, the Commissioner shall
20 consider the desirability and feasibility of contracting with multiple review organizations
21 in order to allow insureds a choice of review organizations and shall ensure that at least
22 one review organization is available to and capable of reviewing cases involving highly
23 specialized services and treatments of any nature. The Commissioner may reject any or
24 all proposals.

25 (c) An independent review organization may seek to modify or withdraw a
26 proposal only after the public opening and only on the basis that the proposal contains an
27 unintentional clerical error as opposed to an error in judgment. An independent review
28 organization seeking to modify or withdraw a proposal shall submit to the Commissioner
29 a written request, with facts and evidence in support of its position, before the
30 determination made by the Commissioner under subsection (b) of this section, but not
31 later than two days after the public opening of the proposals. The Commissioner shall
32 promptly review the request, examine the nature of the error, and determine whether to
33 permit or deny the request.

34 (d) The provisions of Article 3C of Chapter 143 of the General Statutes do not
35 apply to this Part."

36 Section 9. G.S. 58-50-61(a)(13) reads as rewritten:

37 "(13) 'Noncertification' means a determination by an insurer or its
38 designated utilization review organization that an admission,
39 availability of care, continued stay, or other health care service has
40 been reviewed and, based upon the information provided, does not
41 meet the insurer's requirements for medical necessity,
42 appropriateness, health care setting, level of care or effectiveness, or
43 does not meet the prudent layperson standard for coverage of

1 emergency services in G.S. 58-3-190, and the requested service is
2 therefore denied, reduced, or terminated. A 'noncertification' is not a
3 decision rendered solely on the basis that the health benefit plan does
4 not provide benefits for the health care service in question, if the
5 exclusion of the specific service requested is clearly stated in the
6 certificate of coverage. A 'noncertification' includes any situation in
7 which an insurer or its designated agent makes an evaluation or
8 review of medical information about a covered person's condition to
9 determine whether a requested treatment is experimental,
10 investigational, or cosmetic and the extent to which coverage under
11 the health benefit plan is affected by that decision."

12 Section 10. G.S. 58-50-61(a)(17)g. reads as rewritten:

13 "g. Retrospective review. – Utilization review of medically
14 necessary services and supplies that is conducted after services
15 have been provided to a patient, but not the review of a claim that
16 is limited to an evaluation of reimbursement levels, veracity of
17 documentation, accuracy of coding, or adjudication for payment.
18 Retrospective review includes the review of claims for
19 emergency services to determine whether the prudent layperson
20 standard in G.S. 58-3-190 has been met."

21 Section 11. G.S. 58-50-61(i) reads as rewritten:

22 "(i) Requests for Informal Reconsideration. – An insurer may establish procedures
23 for informal reconsideration of noncertifications and if established, such procedures shall
24 be in writing. The reconsideration shall be conducted between the covered person's
25 provider and a medical doctor licensed to practice medicine in this State designated by
26 the ~~insurer~~ insurer, after a written notice of noncertification has been issued in accordance
27 with subsection (h) of this section. An insurer shall not require a covered person to
28 participate in an informal reconsideration before the covered person may appeal a
29 noncertification under subsection (j) of this section. If, after informal reconsideration the
30 insurer upholds the noncertification decision, the insurer shall issue a new notice in
31 accordance with subsection (h) of this section. If the insurer is unable to render an
32 informal reconsideration decision in fewer than 10 business days, it shall treat the request
33 for informal reconsideration as a request for an appeal, except that the requirements of
34 subsection (k) of this section shall apply on or before the 10th business day after receipt
35 of the request for an informal reconsideration."

36 Section 12. G.S. 58-50-62 is amended by adding a new subsection to read:

37 "(b1) Informal Consideration of Grievances. – If the insurer provides procedures for
38 informal considerations of grievances, the procedures shall be in writing and the
39 following requirements apply:

40 (1) If the grievance concerns a clinical issue and the informal consideration
41 decision is not in favor of the covered person, the insurer shall treat the
42 request as a request for a first-level grievance review, except that the

1 requirements of subdivision (e)(1) of this section shall apply on the 10th
2 business day after receipt of the grievance.

3 (2) If the grievance concerns a nonclinical issue and the informal
4 consideration decision is not in favor of the covered person, the insurer
5 shall issue a written decision that includes the information set forth in
6 G.S. 58-50-62(c).

7 (3) If the insurer is unable to render an informal consideration decision
8 within 10 business days of receipt of the grievance, the insurer shall
9 treat the request as a request for a first-level grievance review, except
10 that the requirements of subdivision (e)(1) of this section shall apply on
11 the 10th business day after receipt of the grievance."

12 Section 13. G.S. 58-50-61(k)(5) reads as rewritten:

13 "(5) A statement advising the covered person of the covered person's right to
14 request a second-level grievance review and a description of the
15 procedure for submitting a second-level grievance under ~~G.S. 58-50-62.~~
16 G.S. 58-50-62 if the insurer's decision on the appeal is to uphold its
17 noncertification."

18 Section 14. G.S. 58-50-62(e)(2)e. reads as rewritten:

19 "e. A statement advising the covered person of his or her right to
20 request a second-level grievance review and a description of the
21 procedure for submitting a second-level grievance under this
22 ~~section.~~section if the insurer's decision on the first-level
23 grievance review is not in favor of the covered person."

24 Section 15. G.S. 58-50-62(h)(7) reads as rewritten:

25 "(7) A statement that the decision is the insurer's final determination in the
26 matter. In cases where the review concerned a noncertification and the
27 insurer's decision on the second-level grievance review is to uphold its
28 initial noncertification, a statement advising the covered person of his or
29 her right to request an external review and a description of the
30 procedure for submitting a request for external review to the
31 Commissioner of Insurance."

32 Section 16. The Commissioner of Insurance shall report semiannually to the
33 Joint Legislative Health Care Oversight Committee regarding the nature and
34 appropriateness of reviews conducted under this Part. The report shall include the
35 number of reviews, character of the reviews, dollar amounts in question, and any other
36 information relevant to the evaluation of the effectiveness of the external review
37 procedures established pursuant to this act.

38 Section 17. If any section or provision of this act is declared unconstitutional
39 or invalid by the courts, it does not affect the validity of the act as a whole or any part
40 other than the part so declared to be unconstitutional or invalid.

41 Section 18. This act becomes effective July 1, 2001, and Part 1 of this act
42 applies to claims received on or after July 1, 2001.