GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

HOUSE DRH30202-LN-125 (4/2)

Short Title:	Utiliz. Review & Grievance Amendments.	(Public)
Sponsors:	Representative C. Wilson.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES TO MAKE THEM CONFORM WITH THE UNITED STATES DEPARTMENT OF LABOR CLAIM RULES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The catch line of G.S. 50-59-61 reads as rewritten:

"**§ 58-50-61. Utilization ~~review.~~review, claim determinations, and appeals.**"

SECTION 1.(b) G.S. 58-50-61(a) is amended by adding the following new subdivisions to read:

"(1) 'Adverse benefit determination' means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a health benefit plan, and including the issuance of a noncertification indicating denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(2) 'Claim involving urgent care':

a. Is any claim for medical care or treatment with respect to which the application of the time periods for making nonurgent care determinations:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.
2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

b. Except as provided in sub-subdivision c. of this subsection, whether a claim is a "claim involving urgent care" within the meaning of sub-subdivision a. of this subsection is to be determined by an individual acting on behalf of the insurer applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

c. Any claim that a physician with knowledge of the covered person's medical condition determines is a "claim involving urgent care" within the meaning of sub-subdivision a. of this subsection shall be treated as a "claim involving urgent care" for purposes of this section.

…

(13a) 'Notice' or 'notification' means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR § 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

…

(14a) 'Preservice claim' means any claim for a benefit under a health benefit plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(14b) 'Postservice claim' means any claim for a benefit under a health benefit plan that is not a preservice claim as defined in this section.

…

(16a) 'Relevant', when used to describe a document, record, or other information concerning a covered person's claim, means a document, record, or other information that:

a. Was relied upon in making the benefit determination.

b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination.

c. Demonstrates compliance with the administrative processes and safeguards required pursuant to subdivision (f)(5) of this section in making the benefit determination.

d. Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied treatment option or benefit for the covered person's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination."

SECTION 1.(c) G.S. 58-50-61(a)(6) reads as rewritten:

"(6) "Grievance" means a written complaint submitted by a covered person about any of the following:

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care ~~services.~~services, unless they are about a matter that is subject to an appeal under this section. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

b. Claims payment or handling; or reimbursement for services.

c. The contractual relationship between a covered person and an insurer.

~~d. The outcome of an appeal of a noncertification under this section.~~"

SECTION 1.(d) G.S. 58-50-61(a)(8) reads as rewritten:

"(8) "Health care provider" or "health care professional" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training ~~program;~~ program and also includes a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy."

SECTION 1.(e) G.S. 58-50-61(a)(16) reads as rewritten:

"(16) "Stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the ~~HCFA (Health Care Financing Administration)~~CMS (Centers for Medicare and Medicaid Services) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred."

SECTION 1.(f) The Revisor of Statutes is authorized to renumber the definitions in G.S. 58-50-61(a) to maintain alphabetical order.

SECTION 2. Subsections (b) through (l) of G.S. 58-50-61 read as rewritten:

"(b) Insurer ~~Oversight.~~Oversight of Utilization Review. – Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:

(1) A written description of the URO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the insurer.

(3) A process by which the insurer evaluates the performance of the URO.

(c) Scope and Content of Utilization Review Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.

(2) Data sources and clinical review criteria used in decision making.

(3) The process for conducting appeals of noncertifications.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.

(7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.

(8) The staff position functionally responsible for day-to-day program management.

(9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Utilization Review Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the

Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(e) Insurer ~~Responsibilities.~~ Responsibilities for Utilization Review. – Every insurer shall:

(1) Routinely assess the effectiveness and efficiency of its utilization review program.

(2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.

(3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.

(4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

(5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.

(6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

~~(f) Prospective and Concurrent Reviews. As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered~~

~~person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.~~

~~(g) Retrospective Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification.~~

~~(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.~~

~~(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.~~

~~(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.~~

~~(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:~~

~~(1) The professional qualifications and licensure of the person or persons reviewing the appeal.~~

~~(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.~~

~~(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.~~

~~(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.~~

~~(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.~~

~~(l) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.~~

(f) Obligation to Establish and Maintain Reasonable Claims Procedures. – Every insurer that offers a health benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures to a health benefit plan will be deemed to be reasonable only if:

(1) The claims procedures comply with the requirements of this subsection and subsections (i) through (l) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to subdivision (6) of this subsection.

(2) A description of all claims procedures, including any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures and the applicable time frames is included as part of a summary plan description.

(3) The claims procedures do not contain any provision and are not administered in a way that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the covered person (e.g., the covered person is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim.

(4) The claims procedures do not preclude an authorized representative of a covered person from acting on behalf of such covered person in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, an insurer may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a covered person, provided that, in the case of a claim involving urgent care within the meaning of subdivision (2) of subsection (a) of this section, a health care professional, within the meaning of subdivision (10) of subsection (a) of this section, with knowledge of a covered person's medical condition shall be permitted to act as the authorized representative of the covered person.

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that where appropriate, the plan provisions have been applied consistently with respect to similarly situated covered persons.

(6) The claims procedures provide for the handling of claims filed not in accordance with procedures.

a. The claims procedures provide that, in the case of a failure by a covered person or an authorized representative of a covered person to follow the insurer's procedures for filing a preservice claim, within the meaning of subdivision (18) of subsection (a)

of this section, the covered person or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the covered person or authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the covered person or authorized representative.

b. Sub-subdivision a. of this subdivision shall apply only in the case of a failure that is a communication (i) by a covered person or an authorized representative of a covered person that is received by a person or organizational unit of the insurer that is customarily responsible for handling benefit matters, and (ii) that names a specific covered person, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(7) The claims procedures do not contain any provision and are not administered in a way that requires a covered person to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of ERISA.

(8) To the extent that an insurer offers voluntary levels of appeal other than external review under Part 4 of this Article, including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by subdivision (7) of this subsection, the claims procedures provide that:

a. The insurer waives any right to assert that a covered person has failed to exhaust administrative remedies because the covered person did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the insurer.

b. The insurer agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending.

c. The claims procedures provide that a covered person may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by subdivision (7) of this subsection.

d. The insurer provides to any covered person, upon request, sufficient information relating to the voluntary level of appeal to enable the covered person to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a covered person as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the covered

person's rights to any other benefits under the health benefit plan and information about the applicable rules, the covered person's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

e. No fees or costs are imposed on the covered person as part of the voluntary level of appeal.

(9) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations except to the extent that the health benefit plan or procedures provide that:

a. The arbitration is conducted as one of the two appeals described in subdivision (7) of this subsection and in accordance with the requirements applicable to such appeals.

b. The covered person is not precluded from challenging the decision under section 502(a) of ERISA, external review under Part 4 of this Article, or G.S. 90-21.50 through G.S. 90-21.56.

(g) Claim for Benefits. – For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a covered person in accordance with an insurer's reasonable procedure for filing benefit claims, and a claim for benefits includes any preservice claims within the meaning of subdivision (14a) of subsection (a) of this section and any postservice claims within the meaning of subdivision (14b) of subsection (a) of this section.

(h) Timing of Notification of Benefit Determination. –

(1) The insurer shall notify a covered person of the plan's benefit determination in accordance with sub-subdivisions a. through c. of this subdivision, as appropriate.

a. Urgent care claims. – In the case of a claim involving urgent care, the insurer shall notify the covered person of its benefit determination, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the insurer, unless the covered person fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the health benefit plan. In the case of such a failure, the insurer shall notify the covered person as soon as possible, but not later than 24 hours after its receipt of the claim, of the specific information necessary to complete the claim. The covered person shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection (i)

of this section. The insurer shall notify the covered person of its benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (i) the insurer's receipt of the specified information, or (ii) the end of the period afforded the covered person to provide the specified additional information.

b. Concurrent care decisions. – If an insurer has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

1. Any reduction or termination by the insurer of such course of treatment, other than by plan amendment or termination before the end of such period of time or number of treatments, shall constitute an adverse benefit determination. The insurer shall notify the covered person, in accordance with subsection (i) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

2. Any request by a covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the insurer shall notify the covered person of the benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the insurer at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with subsection (i) of this section, and appeal shall be governed by subdivision (1) of subsection (k) of this section, as appropriate.

c. Other claims. – In the case of a claim not described in sub-subdivision a. or b. of this subdivision, the insurer shall notify the covered person of its benefit determination in accordance with sub-subdivision a. of this subdivision, as appropriate.

1. Preservice claims. – In the case of a preservice claim, the insurer shall notify the covered person of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical

circumstances, but not later than 15 days after its receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the insurer both determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the covered person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If such an extension is necessary due to a failure of the covered person to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the covered person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection (i) of this section.

2. Postservice claims. – In the case of a postservice claim, the insurer shall notify the covered person, in accordance with subsection (i) of this section, of its adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the insurer for up to 15 days, provided that the insurer both determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the covered person, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If such an extension is necessary due to a failure of the covered person to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the covered person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) Calculating time periods. – For purposes of this subsection, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of an insurer, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to sub-subdivision c. of subdivision (1) of this subsection due to a covered person's failure to submit information necessary to decide

a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the covered person until the date on which the covered person responds to the request for additional information.

(i) Manner and Content of Notification of Benefit Determination. –

(1) Except as provided in subdivision (2) of this subsection, the insurer shall provide a covered person with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the covered person:

a. The specific reason or reasons for the adverse determination.

b. Reference to the specific health benefit plan provisions on which the determination is based.

c. A description of any additional material or information necessary for the covered person to perfect the claim and an explanation of why such material or information is necessary.

d. A description of the insurer's appeal procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal and right to request an external review under Part 4 of this Article.

e. In the case of an adverse benefit determination. –

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the covered person upon request.

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

f. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited process applicable to an appeal of such claims.

g. Notice of the availability of the Commissioner's office to provide assistance, including the telephone number and address of the Commissioner's office.

(2) In the case of an adverse benefit determination by an insurer concerning a claim involving urgent care, the information described in subdivision (1) of this subsection may be provided to the covered person orally within the time frame prescribed in sub-subdivision (h)(1)a. of this section, provided that a written or electronic notification in accordance with subdivision (1) of this subsection is furnished to the covered person not later than three days after the oral notification.

(j) Appeal of Adverse Benefit Determinations. –

(1) In general. – Every insurer shall establish and maintain a procedure by which a covered person shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. – The claims procedures of an insurer will not be deemed to provide a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures:

a. Provide covered persons at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

b. Provide covered persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

c. Provide that a covered person shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to the definition provided under subdivision (16a) of subsection (a) of this section.

d. Provide for a review that takes into account all comments, documents, records, and other information submitted by the covered person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) The claims procedures of an insurer will not be deemed to provide a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of sub-subdivisions b. through d. of subdivision (2) of this subsection, the claims procedures:

a. Provide covered persons at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

b. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriately named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

c. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriately named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

d. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the insurer in connection with a covered person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

e. Provide that the health care professional engaged for purposes of a consultation under sub-subdivision c. of this subdivision shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

f. Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the covered person; and (ii) all necessary information, including the insurer's benefit determination on review, shall be transmitted between the insurer and the covered person by telephone, facsimile, or other available similarly expeditious method.

(k) Timing of Notification of Benefit Determination on Appeal. –

(1) The insurer shall notify a covered person of its benefit determination on review in accordance with sub-subdivisions a. through c. of this subdivision as appropriate.

a. Urgent care claims. – In the case of a claim involving urgent care, the insurer shall notify the covered person, in accordance with subsection (l) of this section, of its benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the covered person's request for review of an adverse benefit determination by the insurer.

b. Preservice claims. – In the case of a preservice claim, the insurer shall notify the covered person, in accordance with subsection (l) of this section, of its benefit determination on review within a reasonable period of time appropriate to the medical circumstances as follows:

1. In the case of an insurer that provides for one appeal of an adverse benefit determination, notification shall be provided not later than 30 days after receipt by the insurer of the covered person's request for review of an adverse benefit determination.

2. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level mandatory for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.

3. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level voluntary for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 55 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.

c. Postservice claims. – In the case of a postservice claim, the insurer shall notify the covered person, in accordance with subsection (l) of this section, of its benefit determination on review within a reasonable period of time as follows:

1. In the case of an insurer that provides for one appeal of an adverse benefit determination, notification shall be provided not later than 60 days after receipt by the insurer of the covered person's request for review of an adverse benefit determination.

2. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level mandatory for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.

3. In the case of an insurer that provides for two appeals of an adverse benefit determination and makes the second level voluntary for purposes of a covered person's access to federal remedies under section 502(a) of ERISA, notification shall be provided, with respect to any one of such two appeals, not later than 55 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination.

(2) Calculating time periods. – For purposes of this subsection, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of an insurer, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

(3) Furnishing documents. – In the case of an adverse benefit determination on review, the insurer shall provide such access to, and copies of, documents, records, and other information described in subdivisions (3) and (4) of subsection (l) of this section as is appropriate.

(l) Manner and Content of Notification of Benefit Determination on Appeal. – The insurer shall provide a covered person with written or electronic notification of the insurer's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the covered person:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific health benefit plan provisions on which the adverse benefit determination is based.

(3) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to subdivision (16a) of subsection (a) of this section.

(4) A statement describing any voluntary appeal procedures offered by the insurer and the covered person's right to obtain the information about such procedures described in subdivision (8)d. of subsection (f) of this section, a statement describing the external review process under Part 4 of this Article and the covered person's right to request an external review of an adverse benefit determination that is also a noncertification, and a statement of the covered person's right to bring an action under section 502(a) of ERISA.

a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a

statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request.

b. If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit or other noncertification: (i) either an explanation of the scientific or clinical judgment for the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (ii) a description of the external review process under Part 4 of this Article, a statement of the covered person's right to request an external review, and notice of the availability of the Commissioner's office to provide assistance, including the telephone number and address of the Commissioner's office.

c. The following statement: "You and your insurer may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Department of Insurance." "

SECTION 3. G.S. 58-50-62 reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

(a) Purpose and Intent. – The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered ~~person.~~ person and is not eligible for consideration under the appeal process set out in G.S. 58-50-61. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the insurer of a ~~grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall~~ grievance and shall provide for ~~first- and second-level reviews of grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.~~a formal review of grievances.

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

(1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a ~~first-level~~ grievance review, except that the requirements of subdivision (e)(1) of this section apply on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner;

(2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in subsection (c) of this section; or

(3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance.

(c) Grievance Procedures. – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Maintenance of Records. – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) ~~First Level~~ Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

(1) ~~The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.~~Except as provided in subdivisions (2) through (4) of this subsection, a grievance shall be reviewed in accordance with the standards for review of an appeal of an adverse benefit determination under G.S. 58-50-61, including the requirements for full and fair

review, the requirements for timing of notification for a determination on appeal of a postservice claim, and the requirements for content of notification of decision.

(2) ~~An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:~~

~~a. The professional qualifications and licensure of the person or persons reviewing the grievance.~~

~~b. A statement of the reviewers' understanding of the grievance.~~

~~c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.~~

~~d. A reference to the evidence or documentation used as the basis for the decision.~~

~~e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.~~

Notification of a determination on a grievance review shall include a statement that the decision is the insurer's final determination in the matter.

(3) For grievances concerning the quality of clinical care delivered by the covered person's provider, the insurer shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the covered person that (i) the insurer will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.

(4) Provisions under G.S. 58-50.61(j) and (l) relating to clinical aspects of an appeal of an adverse benefit determination shall apply to grievance review only to the extent that the subject matter of a grievance is clinical in nature.

~~(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or~~

~~the covered person's provider acting on the covered person's behalf may submit a second-level grievance.~~

~~(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:~~

~~a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.~~

~~b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.~~

~~(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.~~

~~(g) Second-Level Grievance Review Procedures. – An insurer's procedures for conducting a second-level grievance review shall include:~~

~~(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.~~

~~(2) The covered person shall be notified in writing at least 15 days before the review meeting date.~~

~~(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.~~

~~(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:~~

~~(1) The professional qualifications and licensure of the members of the review panel.~~

~~(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.~~

~~(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.~~

~~(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.~~

~~(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.~~

~~(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.~~

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

~~(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.~~

~~(i) Expedited Second-Level Procedures. – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.~~

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70."

SECTION 4. This act becomes effective March 1, 2004.