§ 108A-70.29. (Contingently repealed – see note) Program review process.

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

(1) Internal review. – Within 30 days from the date of the decision subject to review under this subsection, a recipient may request a first-level internal review, which shall be conducted by the Clinical Medical Director of the Division of Health Benefits or the Director's clinical designee.

(2) External review. – If the recipient is dissatisfied with the first-level review decision, then within 15 days after the internal review decision is rendered the recipient may request a second-level independent external review by the Department of Health and Human Services Hearing Office. The external review process shall comply with the provisions of 42 C.F.R. § 457.1140. The Department's Hearing Office shall assign the matter to a hearing officer who will preside over the review. The hearing may be in person at the Hearing Office in Raleigh or by telephone. Recipients may:
   a. Represent themselves or have representatives of their choosing in the review process.
   b. Review, in a timely manner, their files and other applicable information relevant to the review of the decision.
   c. Fully participate in the review process, including the opportunity to present supplemental information during the review process.

(3) Time frames. – The hearing officer shall render a written decision within 90 calendar days of the date the recipient requested first-level review, as specified at 42 C.F.R. § 457.1160. If the recipient's physician or health plan determines that operating under the standard 90-day time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, then each level of review must be completed within 72 hours, except that this expedited time frame may be extended by up to 14 calendar days if the recipient requests an extension.

(4) Coverage of services during review. – When the decision is a reduction, suspension, termination, or denied request for increase of existing services, notwithstanding the request for review, the services shall be covered in accordance with the decision under review, and services which are terminated or suspended services shall not be covered, unless and until the decision is overturned on review.

(c) Review of decisions pursuant to Programmatic changes. – The Program review process set forth in this section shall not apply to instances in which the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all

applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

(d) Notice. – A recipient shall receive timely written notice of any decision subject to review under this section in accordance with the requirements of 42 C.F.R. § 457.1180. The notice shall include the reasons for the decision, an explanation of applicable rights to review of that decision, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

(e) Rule-Making authority. – The Department shall have the authority to adopt rules for the implementation and operation of the Program review process.

(f) Additional Rule-Making Authority. – The Department of Health and Human Services shall have the authority to adopt rules for the transition and operation of the North Carolina Health Choice Program. Notwithstanding G.S. 150B-21.1(a), the Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes for enrolling providers to participate in the NC Health Choice Program, for regulating provider participation in the NC Health Choice Program, and for other operational issues regarding the NC Health Choice Program. (2010-70, s. 1; 2010-96, s. 39(a); 2011-145, s. 10.41(e); 2019-81, ss. 7, 15(a); repealed by 2022-74, s. 9D.15(b).)