GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H 2

HOUSE BILL 1107

Committee Substitute Favorable 5/1/03

Short Title: Utiliz. Review & Grievance Amendments. (Public)

Sponsors:

Referred to:

April 10, 2003

1 A BILL TO BE ENTITLED
2 AN ACT TO AMEND THE LAW GOVERNING MANAGED CARE UTILIZATION
3 REVIEW AND GRIEVANCE PROCEDURES TO MAKE THEM CONFORM
4 WITH THE UNITED STATES DEPARTMENT OF LABOR CLAIM RULES.
5 The General Assembly of North Carolina enacts:
6 **SECTION 1.(a)** The catch line of G.S. 58-50-61 reads as rewritten:
7 "**§ 58-50-61. Utilization ~~review.~~ review, claim determinations, and appeals.**
8 **SECTION 1.(b)** G.S. 58-50-61(a) is amended as follows:
9 "(1) "Adverse benefit determination" means any of the following: a denial,
10 reduction, or termination of, or a failure to provide or make payment
11 (in whole or in part) for, a benefit, including any such denial,
12 reduction, termination, or failure to provide or make payment that is
13 based on a determination of a participant's or beneficiary's eligibility to
14 participate in a health benefit plan, and including the issuance of a
15 noncertification indicating denial, reduction, or termination of, or a
16 failure to provide or make payment (in whole or in part) for, a benefit
17 resulting from the application of any utilization review, as well as a
18 failure to cover an item or service for which benefits are otherwise
19 provided because it is determined to be experimental or investigational
20 or not medically necessary or appropriate.
21 (2) "Claim for benefits" means a request for a plan benefit or benefits
22 made by a covered person in accordance with an insurer's reasonable
23 procedure for filing benefit claims, and a claim for benefits includes
24 any preservice claims within the meaning of subdivision (14a) of this
25 subsection and any postservice claims within the meaning of
26 subdivision (14b) of this subsection.
27 (3) "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; or
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.

~~(1)~~(3a) "Clinical peer" means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.

~~(2)~~(3b) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.

~~(3)~~(3c) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.

…

(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.

...

(15a) "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 matter that is not a claim determination, except that any complaint that is solely about the fact that a service which is clearly excluded in the certificate of coverage is an excluded service, and that is not about a claim determination, is not a grievance.

~~a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. 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 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 for 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 (h) through (k) of this section, as appropriate.

(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 certificate or policy of coverage.

(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 (3) of subsection (a) of this section, a health care professional, within the meaning of subdivision (8) 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 (14a) 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) 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 (h) 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 that is permitted under G.S. 58-3-200(c) shall constitute an adverse benefit determination. The insurer shall notify the covered person, in accordance with subsection (h) 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 (h) of this section, and appeal shall be governed by subdivision (1) of subsection (j) 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 (h) of this section.

2. Postservice claims. – In the case of a postservice claim, the insurer shall notify the covered person, in accordance with subsection (h) 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.

(h) 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 ERICA following an adverse benefit determination on appeal, if applicable, and right to request an external review under Part 4 of this Article, if the claim determination is a noncertification.

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 (i) the specific rule, guideline, protocol, or other similar criterion or (ii) 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 assistance from:

1. The Commissioner's office, including the telephone number and address of the Commissioner's office.

2. The Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(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 (g)(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.

(i) 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 appropriately 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 the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

b. 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 (15a) of subsection (a) of this section.

c. 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.

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

e. 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.

f. 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.

g. 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.

h. 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.

i. 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.

(j) 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 (k) 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 (k) 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, for the first level, within 30 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination and, for the second level, within 55 days of 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 (k) 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, for the first level, within 60 days after receipt by the insurer of the covered person's request for review of the adverse benefit determination and, for the second level, within 55 days of 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 (k) of this section as is appropriate.

(k) 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 (15a) of subsection (a) of this section.

(4) A statement describing any appeal procedures, including any voluntary appeal procedures, offered by the insurer and the covered person's right to obtain the information about such procedures described in subsection (f) of this section, 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, if applicable, and a statement

describing the external review process under Part 4 of this Article and the right to request an external review under Part 4 of this Article, if the claim determination is a noncertification.

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 assistance from the Commissioner's office, including the telephone number and address of the Commissioner's office, and the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

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 a grievance. any decision, policy, or action of the insurer that affects that covered person. 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 and Managed Care Patient Assistance Program for assistance, including the telephone number and address of ~~the~~ each 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, when the determination is made at the final level of grievance review.

(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(i) and (k) 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. Provisions under G.S. 58-50-61(j) and (l) that apply only to noncertifications shall not apply to grievance review, except that the requirement under G.S. 58-50-61(j)(4)b. to notify the covered person of the availability of assistance from the Commissioner's office and the Managed Care Patient Assistance Program shall apply.

~~(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. G.S. 58-3-225(c) reads as rewritten:

"(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UP or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information. Any retraction of a determination or reduction of payments that is made because of the discovery of a misrepresentation shall only be made in accordance with G.S. 58-50-61(g) if the determination being reversed is a concurrent care determination."

SECTION 5. G.S. 58-50-75 reads as rewritten:

"**§ 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 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 insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the Teachers' and State Employees' Comprehensive Major Medical Plan, and the Health Insurance Program for Children. ~~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) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.

(3) "Independent review organization" or "organization" means an entity that conducts independent external reviews of appeals of ~~noncertifications and second-level grievance review decisions.~~ noncertifications."

SECTION 6. G.S. 58-50-77 reads as rewritten:

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

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

(1) A noncertification decision under G.S. 58-50-61; and

(2) ~~An appeal decision~~ A notice of determination on an appeal under ~~G.S. 58-50-61~~ G.S. 58-50-61(j) upholding a ~~noncertification; and~~ noncertification.

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

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a noncertification decision under G.S. 58-50-61, a statement informing the covered person that if the covered person has a medical condition where the time frame for completion of an ~~expedited review~~ urgent care claim review of an appeal decision involving a noncertification decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, then the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an ~~expedited review~~ urgent care claim review of an appeal involving a noncertification decision under G.S. 58-50-61, but that the Commissioner will determine whether the covered person shall be required to complete the ~~expedited review~~ urgent care claim review of the grievance before conducting the expedited external review.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of an ~~expedited review of a grievance~~ urgent care claim review involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain

maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an ~~expedited review of a grievance~~ urgent care claim review involving an appeal decision under G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the ~~expedited review~~ urgent care claim review ~~of the grievance~~ before conducting the expedited external review.

(2) If the covered person has not received a written decision from the insurer within ~~60 days after the date the covered person files the second- level grievance with the insurer pursuant to G.S. 58-50-62~~ five days of the date by which the insurer was to have notified the covered person of its determination pursuant to G.S. 58-50-61(j) and the covered person has not requested or agreed to a delay, the covered person may file a request for external review under G.S. 58-50-80 and shall be considered to have exhausted the insurer's internal ~~grievance~~ appeal process for purposes of G.S. 58-50-79.

(d) The insurer shall include in the notice required under subsection (a) of this section for a notice related to ~~a final second-level grievance review decision under G.S. 58-50-62,~~ any notice of determination on an appeal under G.S. 58-50-61(k), a statement informing the covered person that:

(1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the ~~second-level grievance review~~ final appeal decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

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

SECTION 7. G.S. 58-50-79 reads as rewritten:

"**§ 58-50-79. Exhaustion of internal ~~grievance~~ appeal process.**

(a) Except as provided in G.S. 58-50-82, a request for an external review under G.S. 58-50-80 or G.S. 58-50- 82 shall not be made until the covered person has exhausted the insurer's internal appeal ~~and grievance processes~~ process under ~~G.S. 58-50-61 and G.S. 58-50-62.~~ G.S. 58-50-61.

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

(1) Has ~~filed a second level grievance~~ completed the appeals process for ~~involving a~~ noncertification appeal ~~decision~~ decisions under ~~G.S. 58-50-61 and G.S. 58-50-62,~~ G.S. 58-50-61, and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision ~~on the grievance~~ from the insurer within ~~60 days since the date the covered person filed the grievance with the insurer.~~ five days of the date by which the insurer was to have notified the covered person of its determination pursuant to G.S. 58-50-61(j).

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

(d) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal ~~grievance and~~ appeal procedures under G.S. 58-50-61 ~~and G.S. 58-50-62~~ whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal ~~grievance~~ appeal procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82. ~~In addition, the insurer may choose to eliminate the second level grievance review under G.S. 58-50-62.~~ In such case, the covered person may file a request in writing for a standard external review under G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82 within 60 days after receiving notice of an appeal decision upholding a noncertification."

SECTION 8. G.S. 58-50-80(b) reads as rewritten:

"(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

(1) Notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The notice shall include a request for any information that the Commissioner requires to conduct the preliminary review under subdivision (2) of this subsection and require that the insurer deliver the requested information to the Commissioner within three business days of receipt of the notice.

(2) Conduct a preliminary review of the request to determine whether:

a. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

b. The health care service that is the subject of the insurer's noncertification appeal decision ~~or the second level grievance~~

~~review decision upholding a noncertification~~ reasonably appears to be a covered service under the covered person's health benefit plan.

c. The covered person has exhausted the insurer's internal appeal ~~and grievance~~ processes under ~~G.S. 58-50-61 and G.S. 58-50-62,~~ G.S. 58-50-61, unless the covered person is considered to have exhausted the insurer's internal appeal ~~or grievance~~ process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an ~~expedited~~ urgent care claim review of the appeal decision.

d. The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the date of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of that information to the insurer. The Commissioner shall also notify the covered person in writing of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned organization, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal ~~decision or the second-level grievance review~~ decision.

(5) Assign the review to an independent review organization approved under G.S. 58-50-85. The assignment shall be made using an alphabetical list of the independent review organizations, systematically assigning reviews on a rotating basis to the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on

the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.

(6) Forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review."

SECTION 9. G.S. 58-50-80(e) reads as rewritten:

"(e) Failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review. However, if the insurer or its utilization review organization fails to provide the documents and information within the time specified in subdivision (b)(4) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal ~~decision or the second-level grievance review~~ decision. Within one business day of making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner."

SECTION 10. G.S. 58-50-80(g) reads as rewritten:

"(g) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision ~~or second-level grievance review decision~~ that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision ~~or second-level grievance review decision~~ under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision ~~or second-level grievance review decision~~ and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal ~~decision or second-level grievance review~~ decision."

SECTION 11. G.S. 58-50-80(h) reads as rewritten:

"(h) Upon making the decision to reverse its noncertification appeal decision ~~or second-level grievance review decision~~ under subsection (g) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection."

SECTION 12. G.S. 58-50-80(j) reads as rewritten:

"(j) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision ~~or second-level grievance review decision~~ to the covered person, the insurer, the covered person's provider who performed or requested the service, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal ~~grievance~~ appeal process under ~~G.S. 58-50-61 and G.S. 58-50-62.~~ G.S. 58-50-61."

SECTION 13. G.S. 58-50-80(l) reads as rewritten:

"(l) Upon receipt of a notice of a decision under subsection (k) of this section reversing the noncertification appeal ~~decision or second-level grievance review~~

decision, the insurer shall within three business days reverse the noncertification appeal decision ~~or second level grievance review decision~~ that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification appeal ~~decision or second level grievance review~~ decision. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (k) of this section reversing the noncertification appeal ~~decision or second level grievance review~~ decision, the insurer that made the noncertification appeal decision ~~or second level grievance review decision~~ shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment if the service had not been denied when first requested."

SECTION 14. G.S. 58-50-82 reads as rewritten:

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

(a) Except as provided in subsection (g) of this section, a covered person may make a written or oral request for an expedited external review with the Commissioner at the time the covered person receives:

(1) A noncertification decision under ~~G.S. 58-50-61(f)~~ G.S. 58-50-61(g) if:

a. The covered person has a medical condition where the time frame for completion of an ~~expedited~~ urgent care claim review of an appeal involving a noncertification set forth in ~~G.S. 58-50- 61(l)~~ G.S. 58-50-61(j) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for ~~an expedited appeal~~ an urgent care claim review of an appeal under ~~G.S. 58-50-61(l).~~ G.S. 58-50-61(j).

(2) An appeal decision under ~~G.S. 58-50-61(k) or (l)~~ G.S. 58-50-61(j) that is not the insurer's final level of appeal upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an ~~expedited second level grievance review of a noncertification set forth in G.S. 58-50- 62(i)~~ appeal of an urgent care claim would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for ~~an expedited second level review~~ an urgent care claim review of an appeal of a noncertification at the final level of appeal offered by the insurer as set forth in ~~G.S. 58-50-61(i);~~G.S. 58-50-61(j); or

(3) ~~A second level grievance review~~ A final appeal decision under ~~G.S. 58-60-62(h) or (i)~~ G.S. 58-50-61(j) upholding a noncertification:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

b. If the ~~second-level grievance~~ final appeal concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(b) Within three days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the ~~noncertification,~~ noncertification or noncertification appeal ~~decision, or second-level grievance review~~ decision which is the subject of the request that the request has been received and provide a copy of the request or verbally convey all of the information included in the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external review and, if it is eligible, determine whether it is eligible for expedited review.

a. For a request made pursuant to subdivision (a)(1) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an ~~expedited review~~ urgent care claim review of an appeal under ~~G.S. 58-50-61(l)~~ G.S. 58-50-61(j) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner

has not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered person must exhaust, at a minimum, one level of the insurer's internal appeal process under ~~G.S. 58-50-61(l)~~ G.S. 58-50-61(j) before making another request for an external review with the Commissioner.

b. For a request made pursuant to subdivision (a)(2) of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of an ~~expedited review~~ urgent care claim review of an appeal under ~~G.S. 58-50-62~~ G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered persons request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be informed by the Commissioner that the covered person must exhaust the insurer's internal ~~grievance~~ appeal process under ~~G.S. 58-50-62~~ G.S. 58-50-61 to obtain the insurer's final appeal decision before making another request for an external review with the Commissioner.

c. For a request made pursuant to sub-subdivision (a)(3)a. of this section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the

covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall then inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

d. For a request made pursuant to sub-subdivision (a)(3)b. of this section, that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.

(c) As soon as possible, but within the same day of receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision ~~or the second-level grievance review decision~~ to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method.

(d) In addition to the documents and information provided or transmitted under subsection (c) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.
(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.
(6) Medical necessity, as defined in G.S. 58-3-200(b).
(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person’s health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the~~ noncertification,~~ noncertification or noncertification appeal ~~decision, or second-level grievance review ~~decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal ~~grievance ~~appeal process under ~~G.S. 58-50-61 and G.S. 58-50-62.~~ G.S. 58-50-61.

(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(m). Upon receipt of the notice of a decision under subsection (e) of this section that reverses the ~~noncertification,~~ noncertification or noncertification appeal decision, ~~or second-level grievance review decision, ~~the insurer shall within one day reverse the ~~noncertification, ~~noncertification or noncertification appeal~~ decision,~~ decision ~~or second-level grievance review decision~~ that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the~~ noncertification,~~ noncertification or noncertification appeal ~~decision, or second-level grievance review~~ decision.

(g) An expedited external review shall not be provided for retrospective noncertifications."

SECTION 15. G.S. 58-50-84(c) reads as rewritten:

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

SECTION 16. G.S. 58-50-90(c) reads as rewritten:

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

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

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

(3) The average length of time for resolution.

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

(5) The number of external reviews under G.S. 58-50-80 that were terminated as the result of a reconsideration by the insurer of its

noncertification appeal decision ~~or second-level grievance review decision~~ after the receipt of additional information from the covered person.

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

SECTION 17. G.S. 58-50-93(b) reads as rewritten:

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

SECTION 18. This act becomes effective March 1, 2004, and applies to all policies or certificates in effect, delivered, issued for delivery, or renewed on or after that effective date.