GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 935

Short Title: Mgd. Care/Utiliz. & Griev. (Public)

Sponsors: Senator Perdue.

Referred to: Judiciary.

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH PROCEDURES AND RIGHTS FOR MANAGED CARE PLAN MEMBERS IN UTILIZATION REVIEW DECISIONS AND GRIEVANCES AGAINST MANAGED CARE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

Section 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – As used in this section and in G.S. 58-50-62, the term:

(1) 'Adverse determination' means a determination by a carrier or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated. An 'adverse determination' is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

(2) 'Carrier' means an insurance company, multiple employer welfare arrangement, health maintenance organization, or nonprofit hospital or medical service corporation that contracts or offers to contract to arrange for, pay for, or reimburse any of the costs of health care services.

(3) '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.

(4) 'Clinical review criteria' means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a carrier to determine the necessity and appropriateness of health care services.

(5) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. Unless specifically indicated otherwise, 'covered person' includes another person or a provider acting on behalf of a covered person.

(6) 'Emergency services' means health care items and services that are furnished or required to evaluate and treat an emergency medical condition until the condition has been resolved or no material deterioration of the condition is likely, within reasonable medical probability, to result from the omission of immediate further care or result from or occur during the transfer from one facility to another. 'Emergency services' includes ambulance services and ancillary services routinely available to the emergency department. As used in this subdivision, 'emergency medical condition' means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(7) 'Facility' means an institution providing health care services, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

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

a. A carrier's decisions, policies, or actions related to availability, delivery, or quality of health care services.

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

c. The contractual relationship between a covered person and a carrier.

d. The outcome of an appeal of an adverse determination under this section.

(9) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered, or issued by a carrier to provide, deliver, arrange, pay for, or reimburse any of the costs of health care services.

(10) 'Health care professional' means a person authorized under Chapter 90 of the General Statutes to perform health care services.

(11) 'Health care services' means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(12) 'Managed care plan' means a health benefit plan in which a carrier either (i) requires a covered person to use or (ii) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the carrier.

(13) 'Participating provider' means a provider who, under a contract with a carrier or with a carrier's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the carrier, other than coinsurance, copayments, or deductibles.

(14) 'Provider' means a health care professional or a facility.

(15) 'Utilization review' means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.

b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

c. Certification. – A determination by a carrier or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.

e. Discharge planning. – The formal process for determining, before discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

g. Retrospective review. – Utilization review of medical necessity that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

(16) 'Utilization review organization' or 'URO' means an entity that conducts utilization review under a managed care plan, but does not mean a carrier performing utilization review for its own health benefit plan.

(b) Carrier Oversight. – Every carrier shall monitor all utilization review carried out by or on behalf of the carrier and ensure compliance with this section. A carrier shall ensure that appropriate personnel have operational responsibility for the conduct of the carrier's utilization review program. If a carrier contracts to have a URO perform its utilization review, the carrier 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 carrier.

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

(c) Scope and Content of Program. – Every carrier 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 adverse determinations.

(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 carrier'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.

Not later than April 1 of each year, every carrier shall file with the Commissioner a report summarizing its utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review performed, adverse determinations for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and maintains procedures that comply with this section.

(d) Program Operations. – In every utilization review program, a carrier or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. A carrier may develop its own clinical review criteria or purchase or license clinical review criteria. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. Clinical peers shall evaluate the clinical appropriateness of adverse determinations. 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 adverse determinations they render. In issuing a utilization review decision, a carrier 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) Carrier Responsibilities. – Every carrier shall:

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

(2) Use data systems that are sufficient to support utilization review program activities and to generate management reports to enable the carrier to monitor and manage services effectively.

(3) 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.

(4) Provide covered persons 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 and take corrective action when necessary. Every carrier shall annually publish its standards for telephone accessibility as well as the carrier's compliance with those standards.

(5) 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.

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

(7) 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 carrier 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 made by a carrier within two business days after the carrier obtains all necessary information about the admission, procedure, or health care service. If a carrier certifies a health care service, the carrier shall notify the covered person's provider by telephone within one business day after making the certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within two business days after making the certification. The written notification shall include the number of days certified and, if a concurrent review, the number of extended days or next review date, the new total number of days or covered services approved, and the date of admission or initiation of health care services. For an adverse determination, the carrier shall notify the covered person's provider by telephone within one business day after making the determination; and provide written or electronic confirmation of the determination within two business days after making the determination. In concurrent reviews, the carrier shall remain liable for the health care services until the covered person has been notified of the determination and until all appeals and remedies available to the covered person have been exhausted.

(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, a carrier shall make the determination within 30 days after receiving all necessary information. For a certification, the carrier may give written notification to the covered person. For an adverse determination, the carrier shall give written notification to the covered person within five business days after making the adverse determination.

(h) Notice of Adverse Determination.– A written notification of an adverse determination shall include all reasons for the determination, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical review criteria used to make the determination. A carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any person who received the notification of the adverse determination and who follows the procedures for a request.

(i) Requests for Reconsideration. – A carrier may establish procedures for informal reconsideration of adverse determinations. The reconsideration shall occur within one business day after the receipt of the request and shall be conducted between the covered person's provider and a clinical peer designated by the carrier. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be formally appealed by the covered person. A carrier shall not require a covered person to participate in an informal reconsideration before the covered person may appeal an adverse determination under subsection (j) of this section.

(j) Appeals of Adverse Determinations. – Every carrier shall have written procedures for appeals of adverse determinations by covered persons, 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 would jeopardize the covered person's ability to regain maximum function. Appeals shall be evaluated by clinical peers who were not involved in the adverse determinations.

(k) Nonexpedited Appeals. – For standard, nonexpedited appeals, the carrier shall give written notification of the decision to the covered person and the covered person's provider within 30 days after the request for an appeal. The written decision shall contain:

(1) The qualifying credentials 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 carrier'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. 58-51-62.

(l) Expedited Appeals. – An expedited appeal of an adverse determination may be requested by a covered person only when a nonexpedited appeal will cause a delay in the rendering of health care services that would be detrimental to the health of the covered person. The carrier may request documentation of the medical justification for the expedited appeal. The carrier shall provide expedited review by a clinical peer and communicate its decision to the covered person as soon as possible but not later than four days after receiving information justifying expedited review. All necessary information, including the carrier's decision, shall be transmitted between the carrier and the covered person by the most expeditious method available. If the expedited review is a concurrent review determination, the carrier shall remain liable for the coverage of the health care

services until the covered person has been notified of the determination. Every carrier shall provide written confirmation of its decision in an expedited review within two business days after providing notification of that decision if the initial notification was not in writing. The written decision shall contain the provisions specified in subsection (k) of this section. A carrier is not required to provide an expedited review for retrospective adverse determinations.

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, a carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing adverse determinations and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. A carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons. A carrier shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(n) Maintenance of Records. – Every carrier and URO shall maintain records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its decisions; a record of review complaints received; a record of the number and type of noncertifications; a record of the number and outcome of any appeals; and the procedures to ensure confidentiality of medical records and personal information. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to carriers. These records shall be retained by the carrier and URO for a period of three years or until the next general examination by the Commissioner, whichever is later.

(o) Violation. – A violation of this section subjects a carrier to G.S. 58-2-70."

Section 2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

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

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

(b) Availability of Grievance Process. – Every carrier shall have a grievance process whereby covered persons may voluntarily request reviews of decisions, policies, and actions of the carrier. The grievance process shall provide for first- and second-level reviews of grievances; except that an appeal of an adverse determination that has been reviewed under G.S. 58-50-61 shall be reviewed as a second level grievance under this section.

(c) Grievance Procedures. – Every carrier shall have written procedures for receiving and resolving grievances from covered persons. Every carrier shall file with the Commissioner, as part of its annual report required by subsection (d) of this section, a certificate of compliance stating that the carrier has, for each of its lines of business, grievance procedures that comply with this section. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement

informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Grievance Register. – Every carrier shall keep a written register for each calendar year that documents all first- and second-level grievances received during that calendar year. For each grievance, the register shall contain at least a general description of the reason for the grievance; the date received; the date of each review or hearing; the resolution and date of resolution at each level of the grievance; and the name of the covered person for whom the grievance was filed. The register shall be maintained in a manner that is accessible to the Commissioner. The carrier shall retain each register for three years or until the Commissioner has adopted a final report of an examination that contains a review of the register for that calendar year, whichever is later. On or before April 1 of each year, every carrier shall file a report with the Commissioner in a format prescribed by the Commissioner. The report shall include the number of covered lives, the total number of grievances, a brief description of each grievance, the number of grievances referred to the second-level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified.

(e) First-Level Grievance Review. – A grievance may be submitted by a covered person. A carrier shall issue a written decision to the covered person 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. The carrier does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Within three business days after receiving a grievance, the carrier shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. The written decision issued in a first-level grievance review shall contain:

(1) The qualifying credentials of the person or persons reviewing the grievance.

(2) A statement of the reviewers' understanding of the grievance.

(3) 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 carrier's position.

(4) A reference to the evidence or documentation used as the basis for the decision.

(5) 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 G.S. 58-51-62.

(f) Second-Level Grievance Review. – A carrier 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 carrier shall, within three business days after receiving a grievance, make known to the covered person:

(1) The name, address, and telephone number of a person designated to coordinate the grievance review for the carrier.

(2) A statement of a covered person's rights, which include the right to request and receive from a carrier 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 representative of the carrier; and be assisted or represented by a person of his or her choice. A carrier 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 carrier 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 grievance involving an adverse determination shall be health care professionals who have appropriate expertise, including when a clinical decision is involved, at least one clinical peer.

(g) Second-Level Procedures. – A carrier's procedures for conducting a second-level panel 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 review meeting shall be held at a location reasonably accessible to the covered person.

(3) If a carrier is notified in advance that the covered person will not attend the review meeting, the carrier shall offer the covered person the opportunity to communicate with the review panel, at the carrier's expense, by conference call.

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

(5) The carrier shall allow a covered person at least one postponement of the review meeting. A postponed review meeting shall be rescheduled as soon as possible, but shall not be held more than 45 days after receipt of the postponement request.

(6) The covered person may be represented by a private attorney at the review meeting, in which case the carrier may also be represented by an attorney at that meeting.

(7) 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 Review Decisions. – A carrier shall issue a written decision to the covered person within five business days after completing the review meeting. The decision shall include:

(1) The qualifying credentials 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 carrier 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 an adverse determination, a written statement of the clinical rationales, including the clinical review criteria, that were used by the review panel to make the recommendation.
(6) The rationale for the carrier's decision if it differs from the review panel's recommendation.
(7) A statement that the decision is the carrier's final determination in the matter.
(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 carrier 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 carrier shall discriminate against any provider based on any action taken by the provider under this section on behalf of a covered person."

Section 3. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-63. Utilization review and grievance review immunities.**

A person who reviews appeals under G.S. 58-50-61 or G.S. 58-50-62 or a member of a duly appointed grievance review panel under G.S. 58-50-62 who acts without malice or fraud is not subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the provisions of G.S. 58-50-61 or G.S. 58-50-62."

Section 4. G.S. 58-50-65(a) reads as rewritten:

"(a) Nothing in Articles 50 through 55 of this Chapter applies to or affects any policy of liability or workers' compensation insurance, except that the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 through G.S. 58-50-61 and rules adopted under those sections, except where otherwise addressed under the laws and rules of the Industrial Commission, shall apply to policies of workers' compensation insurance."

Section 5. G.S. 58-3-102 and G.S. 58-50-60 are repealed.

Section 6. This act becomes effective January 1, 1998.