GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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HOUSE BILL 351*

Committee Substitute Favorable 4/23/01
Senate Insurance and Consumer Protection Committee Substitute
Adopted 8/29/01

Short Title: Utilization Review and Grievance Changes. (Public)

Sponsors:

Referred to:

March 1, 2001

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES; TO CLARIFY THE DEFINITION OF "HEALTH CARE PROVIDER" IN THE PROMPT PAYMENT LAW; AND TO MAKE A CORRECTION IN THE DEFINITION OF "HMO".

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225(a)(4) reads as rewritten:

"(4) 'Health care provider' means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes <u>or under the laws of another state</u> to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program."

SECTION 2. G.S. 58-50-61(a)(6) reads as rewritten:

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

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. <u>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.</u>

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 3. G.S. 58-50-61(a)(8) reads as rewritten:

"(8) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General ~~Statutes;~~ 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; a health care facility as defined in ~~G.S. 131E-176(9b); or~~ G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy."

SECTION 4. G.S. 58-50-61(a)(13) reads as rewritten:

"(13) 'Noncertification' means a determination by an insurer 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 insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A 'noncertification' 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. A 'noncertification' includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 5. G.S. 58-50-61(a)(17) reads as rewritten:

"(17) '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 an insurer 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 insurer's requirements for medically

necessary services and supplies, 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 provider facility, the coordination and management of the care that a patient receives after discharge from a provider 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 medically necessary services and supplies 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. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

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."

SECTION 6. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of ~~noncertifications.~~ noncertifications and, if established, the procedures shall be in writing. ~~The~~ 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."

SECTION 7. G.S. 58-50-61(k) reads as rewritten:

"(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~~ 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~~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."

SECTION 8. G.S. 58-50-62(b) reads as rewritten:

"(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. 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 provide for first- and second-level reviews of ~~grievances; except that an appeal~~ 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."

SECTION 9. G.S. 58-50-62 is amended by adding the following new subsection to read:

"(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."

SECTION 10. G.S. 58-50-62(e) reads as rewritten:

"(e) First-Level Grievance Review. ~~A grievance maybe submitted by a covered person or his or her provider acting on the covered person's behalf.~~ 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~~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.

(2) An insurer shall issue a written ~~decision~~ 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. ~~The~~ 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.

(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."

SECTION 11. G.S. 58-50-62(f) reads as rewritten:

"(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."

SECTION 12. G.S. 58-65-60(c)(3) reads as rewritten:

"(3) A statement of the terms and conditions, if any, upon which the contract may be cancelled or otherwise terminated at the option of either party. ~~Said~~ The statement shall be in the following language:

a. "Renewability": Any contract subject to the provisions ~~hereof~~ of this subdivision is renewable at the option of the subscriber unless sufficient notice in writing of nonrenewal is mailed to the subscriber by the corporation addressed to the last address recorded with the corporation.

b. "Sufficient notice" shall be as follows:

1. During the first year of any such contract, or during the first year following any lapse and reinstatement, or reenrollment, a period of 30 days.

2. During the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one fourth the number of months of continuous coverage from the first anniversary of the date of issue or reinstatement or reenrollment, whichever date is more recent, to the date of mailing of such notice.

3. No period of required notice shall exceed two years, and no renewal hereunder shall renew any such contract for any period beyond the required period of notice except by written agreement of the subscriber and corporation.

~~Any such~~ The contract may be modified, terminated or cancelled by the corporation at any time at its option, upon:

a. Nonpayment by the subscriber of fees or dues as ~~required, or~~ required.

b. Failure or refusal by the subscriber to comply with rate or benefit changes approved by the ~~State Insurance Department after public hearing as outlined in~~ Commissioner under G.S. 58-65-45.

c. Failure or refusal by the subscriber after 30 days' written notice to subscriber to transfer into ~~hospital and medical and/or~~ hospital, medical, or dental service plan serving the area to which ~~he~~ the subscriber has changed residence and is eligible

for or to which corporation is required to transfer by interplan agreement of transfer.

~~d. The provisions of these amendments to subsection (c) and (c)(3) shall apply only to such contracts as are first issued on and after January 1, 1956.~~"

SECTION 13. G.S. 58-67-5(f) reads as rewritten:

"(f) 'Health maintenance organization' or 'HMO' means any person who undertakes to provide or arrange for the delivery of ~~basic~~ health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles. For the purposes of 11 U.S.C. § 109(b)(2) and (d), an HMO is a domestic insurance company."

SECTION 14. If any section or provision of this act is declared unconstitutional, preempted, or otherwise invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional, preempted, or otherwise invalid.

SECTION 15. This act becomes effective October 1, 2001.