§ 58-50-62. Insurer grievance procedures.

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

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. 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. 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.

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

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

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

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

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

(d) Maintenance of Records. – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for five years or, for domestic companies, 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.

(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.

f. Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(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.

(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.

c. The availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(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.

(9) Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(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. (1997-519, s. 4.2; 2001-417, ss. 8-11; 2001-446, s. 4.6; 2003-105, s. 2(a)-(d); 2008-124, s. 5.2; 2013-199, ss. 16, 17.)