§ 108D-15. Contested case hearings on disputed adverse benefit determinations.

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by a managed care entity. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file a request for an appeal by filing an appeal request form that meets the requirements of subsection (f) of this section with OAH by no later than 120 days after the mailing date of the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The managed care entity shall be the respondent for purposes of this appeal. The managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that, in order to request an appeal, the enrollee must file the form with OAH no later than 120 days after the mailing date of the notice of resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse benefit determination identified in the notice of resolution.

(3a) The option for the enrollee to request an expedited appeal.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) **(Effective until contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an appeal

to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(g) **(Effective once contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

(1) OAH shall schedule and hear cases by no later than 55 days after receipt of a request for a contested case hearing.

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

(3) The administrative law judge assigned to hear the case shall consider and rule on all prehearing motions prior to the scheduled date for a hearing on the merits.

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the managed care entity's expense and made part of the record, including all of the following:

1. A hearing involving medical issues, such as a diagnosis, an examining physician's report, or a decision by a medical review team.
2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the medical assessment performed by an individual involved in any previous level of review or decision making.

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the managed care entity's adverse benefit determination and regardless of whether the managed care entity had an opportunity to consider the evidence in resolving the managed care entity level appeal. Upon the receipt of new evidence and at the request of the managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the managed care entity to review the evidence. Upon reviewing the evidence, if the managed care entity decides to reverse the adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each adverse benefit determination, the administrative law judge shall determine whether the managed care entity substantially prejudiced the rights of the enrollee and whether the managed care entity, based upon evidence at the hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with rights that are no less

than those provided under federal law. (2013-397, s. 1; 2014-100, s. 12H.27(c); 2019-81, s. 1(a); 2021-62, ss. 2.1(g), (h), 2.2(h); 2022-74, s. 9D.15(v).)