§ 135-48.24. Administrative review.

(a) If, after exhaustion of internal appeal handling outlined in the contract with the Claims Processor, any person is aggrieved, then the Claims Processor shall bring the matter to the attention of the Executive Administrator. The Executive Administrator shall promptly decide whether the subject matter of the internal appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The following shall apply to decisions made under this subsection:

(1) The Executive Administrator shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection.

(2) If the Executive Administrator decides that the subject matter raised on internal appeal is not a determination subject to external review, then the Executive Administrator shall have the authority to make a binding decision on the matter.

(3) If the Executive Administrator decides that the subject matter raised on internal appeal is a determination subject to external review, as provided for under subsection (b) of this section, then that decision may be contested by the aggrieved person under Chapter 150B of the General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes.

(b) The State Treasurer, in consultation with the Board of Trustees, shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the State Treasurer, or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's benefit offerings, or requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) Repealed by Session Laws 2011-398, s. 49, effective January 1, 2012, and applicable to contested cases commenced on or after that date. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 53; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 1991, c. 427, s. 6; 2001-446, s. 5(e); 2008-168, ss. 1(a), 2(a), (n); 2011-85, ss. 2.5(g), 2.10; 2011-398, s. 49; 2021-125, s. 3(a).)