GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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SENATE BILL 1324

Short Title: External Review/Managed Care. (Public)

Sponsors: Senators Wellons, Dannelly, Harris; Clodfelter, Forrester, Kinnaird, Lucas, Martin of Guilford, Metcalf, Odom, and Warren.

Referred to: Judiciary I.

June 14, 2000

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE STANDARDS FOR THE ESTABLISHMENT AND
3 MAINTENANCE OF EXTERNAL REVIEW PROCEDURES IN HEALTH
4 INSURANCE AND MANAGED CARE TO ASSURE THAT COVERED PERSONS
5 HAVE THE OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH
6 BENEFIT PLAN COVERAGE DECISION MADE BY THE INSURER OR
7 MANAGED CARE PLAN; AND TO MAKE CONFORMING AMENDMENTS TO
8 EXISTING LAWS ON UTILIZATION REVIEW AND GRIEVANCES.
9 The General Assembly of North Carolina enacts:
10 Section 1. The title of Article 50 of Chapter 58 of the General Statutes reads as
11 rewritten:
12 **"ARTICLE 50.**
13 **GENERAL ACCIDENT AND HEALTH INSURANCE REGULATIONS."**
14 Section 2. Article 50 of Chapter 58 of the General Statutes is amended as
15 follows:
16 (1) By designating G.S. 58-50-1 through G.S. 58-50-45 as
17 Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

Section 3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

Section 4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this ~~section and~~ section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

Section 5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"PART 4. HEALTH BENEFIT PLAN EXTERNAL REVIEW.

"§ 58-50-75. Purpose, scope, and definitions.

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Disclose' means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(3) 'Health information' means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to: the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family; the provision of health care services to an individual; or payment for the provision of health care services to an individual.

1 (4) 'Independent review organization' or 'organization' means an entity that
2 conducts independent external reviews of appeals of noncertifications
3 and second-level grievance review decisions.
4 (5) 'Protected health information' means health information that identifies
5 an individual who is the subject of the information; or with respect to
6 which there is a reasonable basis to believe that the information could
7 be used to identify an individual.
8 "§ 58-50-76: **Reserved for future codification.**
9 "**§ 58-50-77. Notice of right to external review.**
10 (a) An insurer shall notify the covered person in writing of the covered person's
11 right to request an external review and include the appropriate statements and information
12 set forth in this section at the time the insurer sends written notice of a decision on a
13 second-level grievance review in which the insurer upheld its original noncertification as
14 set forth in G.S. 58-50-62.
15 (b) The insurer shall include in the notice required under subsection (a) of this
16 section for a notice related to an appeal decision under G.S. 58-50-61, a statement
17 informing the covered person that:
18 (1) If the covered person has a medical condition where the time frame for
19 completion of an expedited review of a grievance involving an appeal
20 decision under G.S. 58-50-61 would seriously jeopardize the life or
21 health of the covered person or would jeopardize the covered person's
22 ability to regain maximum function, the covered person may file a
23 request for an expedited external review under G.S. 58-50-82 at the
24 same time the covered person files a request for an expedited review of
25 a grievance involving an appeal decision under G.S. 58-50-61 and G.S.
26 58-50-62, but that the organization assigned to conduct the expedited
27 external review will determine whether the covered person shall be
28 required to complete the expedited review of the grievance before
29 conducting the expedited external review.
30 (2) The covered person may file a grievance under the insurer's internal
31 grievance process under G.S. 58-50-61 and G.S. 58-50-62, but if the
32 insurer has not issued a written decision to the covered person within 45
33 days after the date the covered person files the grievance with the
34 insurer and the covered person has not requested or agreed to a delay,
35 the covered person may file a request for external review under G.S. 58-
36 50-80 of this section and shall be considered to have exhausted the
37 insurer's internal grievance process for purposes of G.S. 58-50-79.
38 (c) The insurer shall include in the notice required under subsection (a) of this
39 section for a notice related to a final second-level grievance review decision under G.S.
40 58-50-62, a statement informing the covered person that:
41 (1) If the covered person has a medical condition where the time frame for
42 completion of a standard external review under G.S. 58-50-80 would
43 seriously jeopardize the life or health of the covered person or would

jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or

(2) If the second-level grievance review decision concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person may request an expedited external review under G.S. 58-50-82.

(d) In addition to the information to be provided under subsections (b) and (c) of this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information.

(e) An insurer that has collected protected health information under a valid authorization under this Part may use and disclose the protected health information to a person acting on behalf of or at the direction of the insurer for the performance of the insurer's insurance functions: claims administration, claims adjustment and management, fraud investigation, underwriting, loss control, rate-making functions, reinsurance, risk management, case management, disease management, quality assessment, quality improvement, provider credentialing verification, utilization review, peer review activities, grievance procedures, policyholder service functions, and internal administration of compliance, managerial, and information systems. Additional insurance functions may be allowed for the purpose of this subsection with the prior approval of the Commissioner. The protected health information shall not be used or disclosed for any purpose other than in the performance of the insurer's insurance functions.

(f) Except for a request for an expedited external review under G.S. 58-50-82, all requests for external review shall be made in writing to the Commissioner.

"§ 58-50-78: **Reserved for future codification.**

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) through (g) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62.

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 45 days since the date the covered person filed the grievance with the insurer.

1 (c) Notwithstanding subsection (b) of this section, a covered person may not make
2 a request for an external review of a noncertification involving a retrospective review
3 determination made under G.S. 58-50-61 until the covered person has exhausted the
4 insurer's internal grievance process.
5 (d) At the same time a covered person files a request for an expedited review of an
6 appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person
7 may file a request for an expedited external review of the noncertification under G.S. 58-
8 50-82 if the covered person has a medical condition where the time frame for completion
9 of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-
10 61(j) would seriously jeopardize the life or health of the covered person or would
11 jeopardize the covered person's ability to regain maximum function. An insurer may
12 waive its right to conduct an expedited review of an appeal and allow the covered person
13 to proceed with an expedited external review of the noncertification.
14 (e) Upon receipt of a request for an expedited external review under subsection (d)
15 of this section, the organization conducting the external review in accordance with the
16 provisions of G.S. 58-50-82 shall immediately determine whether the covered person
17 shall be required to complete the expedited review process set forth in G.S. 58-50-61(j)
18 before it conducts the expedited external review, unless the insurer has waived its right to
19 conduct an expedited review of the appeal decision.
20 (f) Upon a determination made under subsection (e) of this section that the
21 covered person must first complete the expedited appeal process under G.S. 58-50-61(j),
22 the organization immediately shall notify the covered person and the insurer of this
23 determination and that it will not proceed with the expedited external review under G.S.
24 58-50-82 until completion of the expedited appeal process and the covered person's
25 grievance at the completion of the expedited appeal process remains unresolved.
26 (g) A request for an external review of a noncertification may be made before the
27 covered person has exhausted the insurer's internal grievance procedures under G.S. 58-
28 50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion
29 requirement.
30 (h) If the requirement to exhaust the insurer's internal grievance procedures is
31 waived under subsection (g) of this section, the covered person may file a request in
32 writing for a standard external review as set forth in G.S. 58-50-80.
33 **"§ 58-50-80. Standard external review.**
34 (a) Within 60 days after the date of receipt of a notice of a noncertification appeal
35 decision or a second-level grievance review decision under G.S. 58-50-77, a covered
36 person may file a request for an external review with the Commissioner.
37 (b) Upon receipt of a request for an external review under subsection (a) of this
38 section, the Commissioner immediately shall notify and send a copy of the request to the
39 insurer that made the decision which is the subject of the request. The insurer shall
40 immediately submit to the Commissioner the information required for the preliminary
41 review under subsection (c) of this section.

1 (c) Within five business days after the date of receipt of a request for an external
2 review, the Commissioner shall complete a preliminary review of the request to
3 determine whether:
4 (1) The individual is or was a covered person in the health benefit plan at
5 the time the health care service was requested or, in the case of a
6 retrospective review, was a covered person in the health benefit plan at
7 the time the health care service was provided.
8 (2) The health care service that is the subject of the noncertification appeal
9 decision or the second-level grievance review decision upholding a
10 noncertification reasonably appears to be a covered service under the
11 covered person's health benefit plan.
12 (3) The covered person has exhausted the insurer's internal grievance
13 process under G.S. 58-50-62(i) unless the covered person is not
14 required to exhaust the insurer's internal grievance process under G.S.
15 58-50-79.
16 (4) The covered person has provided all the information and forms required
17 by the Commissioner that are necessary to process an external review,
18 including the authorization form provided under G.S. 58-50-77(e).
19 (d) Upon completion of the preliminary review under subsection (c) of this
20 section, the Commissioner immediately shall notify the covered person in writing
21 whether the request is complete and whether the request has been accepted for external
22 review.
23 (e) If the request is accepted for external review, the Commissioner shall:
24 (1) Include in the notice provided under subsection (d) of this section a
25 statement that the covered person may submit to the Commissioner in
26 writing within seven days after the date of the notice additional
27 information and supporting documentation that the organization shall
28 consider when conducting the external review.
29 (2) Immediately notify the insurer in writing of the acceptance of the
30 request for external review.
31 (3) Provide the covered person and the covered person's provider with a list
32 of organizations approved under G.S. 58-50-85.
33 (4) Inform the covered person that the covered person has the right to select
34 the organization of his or her choice and notify the Commissioner
35 within five days after receipt of the notice, and that if the covered
36 person does not select an organization and inform the Commissioner of
37 the selection within five days after receipt of the notice, the
38 Commissioner will assign an organization to conduct the external
39 review.
40 (f) If the request is not complete, the Commissioner shall request from the covered
41 person the information or materials needed to make the request complete. The covered
42 person shall furnish the Commissioner with the requested information or materials within
43 90 days after the date of the insurer's decision for which external review is requested. If

1 the request is not accepted for external review, the Commissioner shall inform the
2 covered person and the insurer in writing of the reasons for its nonacceptance.
3 (g) If the insured does not select an organization of his or her choice and notify the
4 Commissioner of the selection within five days after receipt of the Commissioner's notice
5 under subsection (e) of this section, the Commissioner shall systematically assign an
6 appropriate independent review organization that has been approved under G.S. 58-50-85
7 to conduct the external review. In reaching a decision, the assigned organization is not
8 bound by any decisions or conclusions reached during the insurer's utilization review
9 process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-
10 62.
11 (h) Within seven days after the date of receipt of the notice provided under
12 subsection (e) of this section, the insurer or its designee utilization review organization
13 shall provide to the assigned organization, the documents and any information considered
14 in making the noncertification appeal decision or the second-level grievance review
15 decision. Except as provided in subsection (i) of this section, failure by the insurer or its
16 designee utilization review organization to provide the documents and information within
17 the time specified in this subsection shall not delay the conduct of the external review.
18 (i) If the insurer or its utilization review organization fails to provide the
19 documents and information within the time specified in subsection (h) of this section, the
20 assigned organization may terminate the external review and make a decision to reverse
21 the noncertification appeal decision or the second-level grievance review decision.
22 Immediately upon making the decision under this subsection, the organization shall
23 notify the covered person, the insurer, and the Commissioner.
24 (j) The assigned organization shall review all of the information and documents
25 received under subsections (h) and (i) of this section and any other information submitted
26 in writing by the covered person under subsection (e) of this section that has been
27 forwarded to the organization by the Commissioner. Upon receipt of any information
28 submitted by the covered person under subsection (e) of this section, at the same time the
29 Commissioner forwards the information to the organization, the Commissioner shall
30 forward the information to the insurer.
31 (k) Upon receipt of the information required to be forwarded under subsection (j)
32 of this section, the insurer may reconsider its noncertification appeal decision or second-
33 level grievance review decision that is the subject of the external review. Reconsideration
34 by the insurer of its noncertification appeal decision or second-level grievance review
35 decision under this subsection shall not delay or terminate the external review. The
36 external review shall be terminated if the insurer decides, upon completion of its
37 reconsideration, to reverse its noncertification appeal decision or second-level grievance
38 review decision and provide coverage or payment for the requested health care service
39 that is the subject of the noncertification appeal decision or second-level grievance
40 review decision.
41 (l) Immediately upon making the decision to reverse its noncertification appeal
42 decision or second-level grievance review decision under subsection (k) of this section,
43 the insurer shall notify the covered person, the organization, and the Commissioner in

writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(m) In addition to the documents and information provided under subsections (h) and (i) of this section, the assigned organization, to the extent the documents or information are available and the organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's medical records.
(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The terms of coverage under the covered person's health benefit plan with the insurer to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.
(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations. Local practice guidelines may be used when appropriate.
(6) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
(7) Medical necessity, as defined in G.S. 58-3-200(b).

(n) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner.

(o) The organization shall include in the notice sent under subsection (n) of this section:

(1) A general description of the reason for the request for external review.
(2) The date the organization received the assignment from the Commissioner to conduct the external review.
(3) The date the organization received information and documents submitted by the covered person and by the insurer.
(4) The date the external review was conducted.
(5) The date of its decision.
(6) The principal reason or reasons for its decision.
(7) The clinical rationale for its decision.
(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
(9) The professional qualifications and licensure of the clinical peer reviewers.

1 (10) Notice to the covered person that he or she is not liable for the cost of
2 the external review.
3 (p) Upon receipt of a notice of a decision under subsection (n) of this section
4 reversing the noncertification appeal decision or second-level grievance review decision,
5 the insurer immediately shall approve the coverage that was the subject of the
6 noncertification appeal decision or second-level grievance review decision.
7 "§ 58-50-81: **Reserved for future codification.**
8 "**§ 58-50-82. Expedited external review.**
9 (a) Except as provided in subsection (g) of this section, a covered person may
10 make a request for an expedited external review with the Commissioner at the time the
11 covered person receives:
12 (1) An appeal decision upholding a noncertification if:
13 a. The noncertification appeal decision involves a medical
14 condition of the covered person for which the time frame for
15 completion of an expedited second-level grievance review of a
16 noncertification set forth in G.S. 58-50-62(l) would seriously
17 jeopardize the life or health of the covered person or would
18 jeopardize the covered person's ability to regain maximum
19 function; and
20 b. The covered person has filed a request for an expedited appeal of
21 a noncertification as set forth in G.S. 58-50-61(l); or
22 (2) A second-level grievance review decision upholding a noncertification
23 under G.S. 58-50-62(h) or (i):
24 a. If the covered person has a medical condition where the time
25 frame for completion of a standard external review under G.S.
26 58-50-80 would seriously jeopardize the life or health of the
27 covered person or would jeopardize the covered person's ability
28 to regain maximum function; or
29 b. If the second-level grievance concerns a noncertification of an
30 admission, availability of care, continued stay, or health care
31 service for which the covered person received emergency
32 services, but has not been discharged from a facility.
33 (b) At the time the Commissioner receives a request for an expedited external
34 review, the Commissioner immediately shall:
35 (1) Notify and provide a copy of the request to the insurer that made the
36 noncertification appeal decision or second-level grievance review
37 decision which is the subject of the request.
38 (2) For a request that the Commissioner has determined meets the
39 reviewability requirements set forth in G.S. 58-50-80(c), assign an
40 organization that has been approved under G.S. 58-50-87. The
41 organization shall immediately determine whether the request should be
42 reviewed on an expedited basis because the time frame for completion
43 of a standard external review under G.S. 58-50-80 would seriously

1 jeopardize the life or health of the covered person or would jeopardize
2 the covered person's ability to regain maximum function. The
3 organization shall then inform the covered person, insurer, and
4 Commissioner of its determination and conduct a review and make a
5 decision on the review within the appropriate time frame.
6 (c) In reaching a decision, the assigned organization is not bound by any decisions
7 or conclusions reached during the insurer's utilization review process or internal
8 grievance process under G.S. 58-50-61 and G.S. 58-50-62.
9 (d) At the time the insurer receives the notice under subsection (b) of this section,
10 the insurer or its designee utilization review organization shall immediately provide or
11 transmit all necessary documents and information considered in making the final
12 noncertification decision to the assigned organization electronically or by telephone or
13 facsimile or any other available expeditious method.
14 (e) In addition to the documents and information provided or transmitted under
15 subsection (d) of this section, the assigned organization, to the extent the information or
16 documents are available and the organization considers them appropriate, shall consider
17 the following in reaching a decision:
18 (1) The covered person's pertinent medical records.
19 (2) The attending health care provider's recommendation.
20 (3) Consulting reports from appropriate health care providers and other
21 documents submitted by the insurer, covered person, or the covered
22 person's treating provider.
23 (4) The terms of coverage under the covered person's health benefit plan
24 with the insurer to ensure that the organization's decision shall not be
25 contrary to the terms of coverage under the covered person's health
26 benefit plan with the insurer.
27 (5) The most appropriate practice guidelines, which may include generally
28 accepted practice guidelines, evidence-based practice guidelines, or any
29 other practice guidelines developed by the federal government, national
30 or professional medical societies, boards, and associations. Local
31 practice guidelines may be used when appropriate.
32 (6) Any applicable clinical review criteria developed and used by the
33 insurer or its designee utilization review organization in making
34 noncertification decisions.
35 (7) Medical necessity, as defined in G.S. 58-3-200(b).
36 (f) As expeditiously as the covered person's medical condition or circumstances
37 require, but not more than four days after the date of receipt of the request for an
38 expedited external review, the assigned organization shall make a decision to uphold or
39 reverse the noncertification appeal decision or second-level grievance review decision
40 and notify the covered person, the insurer, and the Commissioner of the decision.
41 (g) If the notice provided under subsection (f) of this section was not in writing,
42 within two days after the date of providing that notice, the assigned organization shall
43 provide written confirmation of the decision to the covered person, the insurer, and the

1 Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of
2 the notice, a decision under subsection (f) of this section reversing the noncertification
3 appeal decision or second-level grievance review decision, the insurer immediately shall
4 approve the coverage that was the subject of the noncertification.
5 (h) An expedited external review may not be provided for retrospective
6 noncertifications.
7 "§ 58-50-83: **Reserved for future codification.**
8 "**§ 58-50-84. Binding nature of external review decision.**
9 (a) An external review decision is binding on the insurer.
10 (b) An external review decision is binding on the covered person except to the
11 extent the covered person has other remedies available under applicable federal or State
12 law.
13 (c) A covered person may not file a subsequent request for external review
14 involving the same noncertification appeal decision or second-level grievance review
15 decision for which the covered person has already received an external review decision
16 under this Part.
17 "**§ 58-50-85. Approval of independent review organizations.**
18 (a) The Commissioner shall approve independent review organizations eligible to
19 be assigned to conduct external reviews under this Part to ensure that an organization
20 satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner
21 shall develop an application form for initially approving and for reapproving
22 organizations to conduct external reviews.
23 (b) Any organization wishing to be approved to conduct external reviews under
24 this Part shall submit the application form and include with the form all documentation
25 and information necessary for the Commissioner to determine if the organization satisfies
26 the minimum qualifications established under G.S. 58-50-87.
27 (c) The Commissioner may, in his discretion, determine that accreditation by a
28 nationally recognized private accrediting entity with established and maintained
29 standards for independent review organizations that meet the minimum qualifications
30 established under G.S. 58-50-87 will cause an independent review organization to be
31 deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-
32 87. A decision by the Commissioner to recognize an accreditation program for the
33 purpose of granting deemed status may be made only after reviewing the accreditation
34 standards and program information submitted by the accrediting body. An independent
35 review organization seeking deemed status due to its accreditation shall submit original
36 documentation issued by the accrediting body to demonstrate its accreditation.
37 (d) The Commissioner may charge an application fee that independent review
38 organizations shall submit to the Commissioner with an application for approval and
39 reapproval.
40 (e) An approval is effective for two years, unless the Commissioner determines
41 before expiration of the approval that the independent review organization is not
42 satisfying the minimum qualifications established under G.S. 58-50-87.

(f) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the Commissioner under subsection (g) of this section.

(g) The Commissioner shall maintain and periodically update a list of approved independent review organizations.

"§ 58-50-86: **Reserved for future codification.**

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:
   a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.
   b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.
   c. The confidentiality of medical and treatment records and clinical review criteria.
   d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating

patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license from the North Carolina Medical Board and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted North Carolina license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review

organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"§ 58-50-88: **Reserved for future codification.**

"**§ 58-50-89. Hold harmless for independent review organizations.**

No independent review organization or clinical peer reviewer working on behalf of an organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(6) Any other information the Commissioner may request or require.

(d) The organization shall retain the written records required under this section for at least three years.

1 (e) Each insurer shall maintain written records in the aggregate and for each type
2 of health benefit plan offered by the insurer on all requests for external review of which
3 the insurer receives notice from the Commissioner under this Part. The insurer shall
4 retain the written records required under this section for at least three years.
5 "§ 58-50-91: **Reserved for future codification.**
6 "**§ 58-50-92. Funding of external review.**
7 The insurer against which a request for a standard external review or an expedited
8 external review is filed shall reimburse the Department of Insurance for the fees charged
9 by the organization in conducting the external review.
10 "**§ 58-50-93. Disclosure requirements.**
11 (a) Each insurer shall include a description of the external review procedures in or
12 attached to the policy, certificate, membership booklet, outline of coverage, or other
13 evidence of coverage it provides to covered persons.
14 (b) The description required under subsection (a) of this section shall include a
15 statement that informs the covered person of the right of the covered person to file a
16 request for an external review of a noncertification appeal decision or a second-level
17 grievance review decision upholding a noncertification with the Commissioner. The
18 statement shall include the telephone number and address of the Commissioner.
19 (c) In addition to subsection (b) of this section, the statement shall inform the
20 covered person that, when filing a request for an external review, the covered person will
21 be required to authorize the release of any medical records of the covered person that
22 may be required to be reviewed for the purpose of reaching a decision on the external
23 review.
24 "**§ 58-50-94. Competitive selection of independent review organizations.**
25 (a) The Commissioner shall prepare and publish requests for proposals from
26 independent review organizations that want to be approved under G.S. 58-50-85. All
27 proposals shall be sealed. The Commissioner shall open all proposals in public.
28 (b) After the public opening, the Commissioner shall review the proposals,
29 examining the costs and quality of the services offered by the independent review
30 organizations, the reputation and capabilities of the independent review organizations
31 submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The
32 Commissioner shall determine which proposal or proposals would satisfy the provisions
33 of this Part. The Commissioner shall make his determination in consultation with an
34 evaluation committee whose membership includes representatives of insurers subject to
35 Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and
36 insureds. In selecting the review organizations, in addition to considering cost, quality,
37 and adherence to the requirements of the request for proposals, the Commissioner shall
38 consider the desirability and feasibility of contracting with multiple review organizations
39 in order to allow insureds a choice of review organizations and shall ensure that at least
40 one review organization is available to and capable of reviewing cases involving highly
41 specialized services and treatments of any nature. The Commissioner may reject any or
42 all proposals.

1 (c) An independent review organization may seek to modify or withdraw a
2 proposal only after the public opening and only on the basis that the proposal contains an
3 unintentional clerical error as opposed to an error in judgment. An independent review
4 organization seeking to modify or withdraw a proposal shall submit to the Commissioner
5 a written request, with facts and evidence in support of its position, before the
6 determination made by the Commissioner under subsection (b) of this section, but not
7 later than two days after the public opening of the proposals. The Commissioner shall
8 promptly review the request, examine the nature of the error, and determine whether to
9 permit or deny the request.
10 (d) The provisions of Article 3C of Chapter 143 of the General Statutes do not
11 apply to this Part.
12 "**§ 58-50-95. Report by Commissioner.**
13 The Commissioner shall report semiannually to the Joint Legislative Health Care
14 Oversight Committee regarding the nature and appropriateness of reviews conducted
15 under this Part. The report should include the number of reviews, character of the
16 reviews, dollar amounts in question, and any other information relevant to the evaluation
17 of the effectiveness of this Part."
18 Section 6. G.S. 58-50-61(a)(13) reads as rewritten:
19 "(13) 'Noncertification' means a determination by an insurer or its
20 designated utilization review organization that an admission,
21 availability of care, continued stay, or other health care service has
22 been reviewed and, based upon the information provided, does not
23 meet the insurer's requirements for medical necessity,
24 appropriateness, health care setting, level of care or effectiveness, or
25 does not meet the prudent layperson standard for coverage of
26 emergency services in G.S. 58-3-190, and the requested service is
27 therefore denied, reduced, or terminated. A 'noncertification' is not a
28 decision rendered solely on the basis that the health benefit plan does
29 not provide benefits for the health care service in question, if the
30 exclusion of the specific service requested is clearly stated in the
31 certificate of coverage. A 'noncertification' includes any situation in
32 which an insurer or its designated agent makes an evaluation or
33 review of medical information about a covered person's condition to
34 determine whether a requested treatment is experimental,
35 investigational, or cosmetic and the extent to which coverage under
36 the health benefit plan is affected by that decision."
37 Section 7. G.S. 58-50-61(a)(17)g. reads as rewritten:
38 "g. Retrospective review. – Utilization review of medically
39 necessary services and supplies that is conducted after services
40 have been provided to a patient, but not the review of a claim that
41 is limited to an evaluation of reimbursement levels, veracity of
42 documentation, accuracy of coding, or adjudication for payment.
43 Retrospective review includes the review of claims for

1 emergency services to determine whether the prudent layperson
2 standard in G.S. 58-3-190 has been met."
3 Section 8. G.S. 58-50-61(i) reads as rewritten:
4 "(i) Requests for Informal Reconsideration. – An insurer may establish procedures
5 for informal reconsideration of noncertifications and if established, such procedures shall
6 be in writing. The reconsideration shall be conducted between the covered person's
7 provider and a medical doctor licensed to practice medicine in this State designated by
8 the ~~insurer~~ insurer, after a written notice of noncertification has been issued in accordance
9 with subsection (h) of this section. An insurer shall not require a covered person to
10 participate in an informal reconsideration before the covered person may appeal a
11 noncertification under subsection (j) of this section. If, after informal reconsideration the
12 insurer upholds the noncertification decision, the insurer shall issue a new notice in
13 accordance with subsection (h) of this section. If the insurer is unable to render an
14 informal reconsideration decision in fewer than 10 business days, it shall treat the request
15 for informal reconsideration as a request for an appeal, except that the requirements of
16 subsection (k) of this section shall apply on or before the 10th business day after receipt
17 of the request for an informal reconsideration."
18 Section 9. G.S. 58-50-62 is amended by adding a new subsection to read:
19 "(b1) Informal Consideration of Grievances. – If the insurer provides procedures for
20 informal considerations of grievances, the procedures shall be in writing and the
21 following requirements apply:
22 (1) If the grievance concerns a clinical issue and the informal consideration
23 decision is not in favor of the covered person, the insurer shall treat the
24 request as a request for a first-level grievance review, except that the
25 requirements of subdivision (e)(1) of this section shall apply on the 10th
26 business day after receipt of the grievance.
27 (2) If the grievance concerns a nonclinical issue and the informal
28 consideration decision is not in favor of the covered person, the insurer
29 shall issue a written decision that includes the information set forth in
30 G.S. 58-50-62(c).
31 (3) If the insurer is unable to render an informal consideration decision
32 within 10 business days of receipt of the grievance, the insurer shall
33 treat the request as a request for a first-level grievance review, except
34 that the requirements of subdivision (e)(1) of this section shall apply on
35 the 10th business day after receipt of the grievance."
36 Section 10. G.S. 58-50-61(k)(5) reads as rewritten:
37 "(5) A statement advising the covered person of the covered person's right to
38 request a second-level grievance review and a description of the
39 procedure for submitting a second-level grievance under ~~G.S 58-50-62.~~
40 G.S. 58-50-62 if the insurer's decision on the appeal is to uphold its
41 noncertification."
42 Section 11. G.S. 58-50-62(e)(2)e. reads as rewritten:

"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.~~ section if the insurer's decision on the first-level grievance review is not in favor of the covered person."

Section 12. G.S. 58-50-62(h)(7) reads as rewritten:

"(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."

Section 13. The Commissioner of Insurance shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report shall include the number of reviews, character of the reviews, dollar amounts in question, and any other information relevant to the evaluation of the effectiveness of the external review procedures established pursuant to this act.

Section 14. If any section or provision of this act is declared unconstitutional or 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 or invalid.

Section 15. This act becomes effective July 1, 2001.