GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

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SENATE DRS65170-LN-113 (3/26)

Short Title:	Mngd Care/Health Benefits Clarifying Changes.	(Public)
Sponsors:	Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PROMPT PAY LAW TO CLARIFY THAT A "CLAIMANT" UNDER THE LAW INCLUDES "AN INSURED"; THAT THIRTY DAYS REFERENCES ARE TO THIRTY "CALENDAR" DAYS; THAT THE NINETY-DAY DEADLINE FOR RESPONDING TO ADDITIONAL INFORMATION REQUESTS FROM AN INSURER ONLY APPLIES TO CLAIMS NOT ALREADY DENIED; TO REQUIRE, UNDER THE PROMPT PAY LAWS, A STATUS REPORT WHEN CLAIMS ARE NOT PAID OR DENIED WITHIN SIXTY DAYS EVEN WHEN THE INSURER IS AWAITING INFORMATION REQUESTED FROM THE CLAIMANT; TO REMOVE FROM THE UNIFORM CREDENTIALING STATUTE AN UNNECESSARY PROVISION; AND TO AMEND UTILIZATION REVIEW LAWS TO CLARIFY THAT A SECOND-LEVEL GRIEVANCE REVIEW PANEL MAY CONSIST OF ONE OR MORE PERSONS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

(a) As used in this section:

(1) "Claimant" includes the insured or a health care provider or facility that is responsible or permitted under contract with the insurer or by valid assignment of benefits for directly making the claim with an insurer.

…"

SECTION 1.(b) G.S. 58-3-225(c) through (f) read as rewritten:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

…

(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 calendar days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or ~~HCFA~~ CMS form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 calendar days after receiving the additional information.

(d) If a claim has not already been denied, an insurer requests additional information under subsection (c) of this ~~section~~ section, and the insurer does not receive the additional information within 90 calendar days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st calendar day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the

claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 calendar days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 calendar days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than 180 calendar days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

…"

SECTION 1.(c) G.S. 58-3-225(g) reads as rewritten:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

…

(g) If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 calendar days after receipt of the initial claim, the insurer shall send a claim status report to the insured. ~~Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section.~~ The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider 30 calendar days after the previous report was sent."

SECTION 2. G.S. 58-3-230(a) reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care ~~practitioner, or applicant for licensure as a health care practitioner,~~ practitioner within 60 calendar days of receipt of a completed provider credentialing application form approved by the Commissioner. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

…"

SECTION 3. G.S. 58-50-62(f) reads as rewritten:

"**§ 58-50-62. Insurer grievance procedures.**

…

(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 consisting of one or more persons 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.~~ No person on the panel shall have been previously involved in any matter giving rise to the second-level grievance, shall be an employee of the insurer or URO, or shall 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~~ Each panel member reviewing a second-level grievance involving a noncertification or a clinical issue shall be ~~providers who have appropriate expertise,~~ a provider who has appropriate expertise, and each panel reviewing a second-level grievance involving a noncertification or a clinical issue shall include ~~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 4. Section 1(c) of this act becomes effective January 1, 2004. The remainder of this act is effective when it becomes law.