

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2003

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SENATE BILL 607

Short Title: Mngd Care/Health Benefits Clarifying Changes.

(Public)

Sponsors: Senator Purcell.

Referred to: Commerce.

March 31, 2003

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

1 or cannot be paid because the proof of loss is inadequate or incomplete, or not paid  
2 pending receipt of requested coordination of benefits information, the notice shall  
3 contain the specific good faith reason or reasons why the claim has not been paid and an  
4 itemization or description of all of the information needed by the insurer to complete the  
5 processing of the claim. If all or part of the claim is contested or cannot be paid because  
6 of the application of a specific utilization management or medical necessity standard is  
7 not satisfied, the notice shall contain the specific clinical rationale for that decision or  
8 shall refer to specific provisions in documents that are made readily available through  
9 the insurer which provide the specific clinical rationale for that decision; however, if a  
10 notice of noncertification has already been provided under G.S. 58-50-61(h), then the  
11 specific clinical rationale for the decision is not required under this subsection. If the  
12 claim is contested or cannot be paid because of nonpayment of premiums, the notice  
13 shall contain a statement advising the claimant of the nonpayment of premiums. If a  
14 claim is not paid pending receipt of requested coordination of benefits information, the  
15 notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the  
16 undisputed portion of the claim within 30 calendar days after receipt of the claim and  
17 send the notice of the denial or contested status within 30 calendar days after receipt of  
18 the claim. If a claim is contested or cannot be paid because the claim was not submitted  
19 on the required form, the notice shall contain the required form, if the form is other than  
20 a UB or ~~HCFA~~-CMS form, and instructions to complete that form. Upon receipt of  
21 additional information requested in its notice to the claimant, the insurer shall continue  
22 processing the claim and pay or deny the claim within 30 calendar days after receiving  
23 the additional information.

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

33 (e) Health benefit plan claim payments that are not made in accordance with this  
34 section shall bear interest at the annual percentage rate of eighteen percent (18%)  
35 beginning on the date following the day on which the claim should have been paid. If  
36 additional information was requested by the insurer under subsection (b) of this section,  
37 interest on health benefit claim payments shall begin to accrue on the 31st calendar day  
38 after the insurer received the additional information. A payment is considered made on  
39 the date upon which a check, draft, or other valid negotiable instrument is placed in the  
40 United States Postal Service in a properly addressed, postpaid envelope, or, if not  
41 mailed, on the date of the electronic transfer or other delivery of the payment to the  
42 claimant. This subsection does not apply to claims for benefits that are not covered by  
43 the health benefit plan; nor does this subsection apply to deductibles, co-payments, or  
44 other amounts for which the insurer is not liable.

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

11 ..."

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

13 **"§ 58-3-225. Prompt claim payments under health benefit plans.**

14 ...

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

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

25 **"§ 58-3-230. Uniform provider credentialing.**

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

35 ..."

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

37 **"§ 58-50-62. Insurer grievance procedures.**

38 ...

39 (f) **Second-Level Grievance Review.** – An insurer shall establish a second-level  
40 grievance review process for covered persons who are dissatisfied with the first-level  
41 grievance review decision or a utilization review appeal decision. A covered person or  
42 the covered person's provider acting on the covered person's behalf may submit a  
43 second-level grievance.

- 1 (1) An insurer shall, within 10 business days after receiving a request for a  
2 second-level grievance review, make known to the covered person:  
3 a. The name, address, and telephone number of a person  
4 designated to coordinate the grievance review for the insurer.  
5 b. A statement of a covered person's rights, which include the  
6 right to request and receive from an insurer all information  
7 relevant to the case; attend the second-level grievance review;  
8 present his or her case to the review panel; submit supporting  
9 materials before and at the review meeting; ask questions of any  
10 member of the review panel; and be assisted or represented by a  
11 person of his or her choice, which person may be without  
12 limitation to: a provider, family member, employer  
13 representative, or attorney. If the covered person chooses to be  
14 represented by an attorney, the insurer may also be represented  
15 by an attorney.
- 16 (2) An insurer shall convene a second-level grievance review panel  
17 consisting of one or more persons for each request. ~~The panel shall~~  
18 ~~comprise persons who were not previously involved in any matter~~  
19 ~~giving rise to the second level grievance, are not employees of the~~  
20 ~~insurer or URO, and do not have a financial interest in the outcome of~~  
21 ~~the review. No person on the panel shall have been previously~~  
22 ~~involved in any matter giving rise to the second-level grievance, shall~~  
23 ~~be an employee of the insurer or URO, or shall have a financial~~  
24 ~~interest in the outcome of the review.~~ A person who was previously  
25 involved in the matter may appear before the panel to present  
26 information or answer questions. ~~All of the persons~~ Each panel  
27 member reviewing a second-level grievance involving a  
28 noncertification or a clinical issue shall be ~~providers who have~~  
29 ~~appropriate expertise, a provider who has appropriate expertise, and~~  
30 each panel reviewing a second-level grievance involving a  
31 noncertification or a clinical issue shall include ~~including~~ at least one  
32 clinical peer. Provided, however, an insurer that uses a clinical peer on  
33 an appeal of a noncertification under G.S. 58-50-61 or on a first-level  
34 grievance review panel under this section may use one of the insurer's  
35 employees on the second-level grievance review panel in the same  
36 matter if the second-level grievance review panel comprises three or  
37 more persons.

38 ..."

39 **SECTION 4.** Section 1(c) of this act becomes effective January 1, 2004. The  
40 remainder of this act is effective when it becomes law.