GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1999

HOUSE BILL 1340
RATIFIED BILL

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT, TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS UNDER HEALTH BENEFIT PLANS, AND TO MAKE CONFORMING AMENDMENTS TO RELATED CLAIM PAYMENT LAWS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"**ARTICLE 38.**
"**RESPIRATORY CARE PRACTICE ACT.**

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. – The North Carolina Respiratory Care Board.
(2) Diagnostic testing. – Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.
(3) Direct supervision. – The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.
(4) Individual. – A human being.
(5) License. – A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.
(6) Licensee. – A person who has been issued a license under this Article.
(7) Medical director. – An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.
(8) Person. – An individual, corporation, partnership, association, unit of government, or other legal entity.
(9) Physician. – A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. – As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. New and innovative respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the American Association of Respiratory Care.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. – As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. – A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. – Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"**§ 90-649. North Carolina Respiratory Care Board; creation.**

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of 10 members as follows:

(1) Two members shall be respiratory care practitioners.

(2) Four members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.

(3) One member shall represent the NCHA.

(4) One member shall represent the North Carolina Association of Medical Equipment Services.

(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person

engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"**§ 90-650. Appointments and removal of Board members; terms and compensation.**

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The Old North State Medical Society shall appoint one of the physician members described in G.S. 96-649(a)(2).

(6) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(7) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of November immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.
(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.
(3) Adopt and publish a code of ethics.
(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.
(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.
(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.
(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.
(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.
(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.
(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.
(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.
(12) Request and receive the assistance of State educational institutions or other State agencies.
(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.
(2) Submit any fees required by the Board.
(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.
(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.
(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"**§ 90-654. Exemption from certain requirements.**

(a) The Board may issue a license to an applicant who, as of October 1, 2000, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2002.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 2000, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2002, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"**§ 90-655. Licensure by reciprocity.**

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"**§ 90-656. Provisional license.**

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"**§ 90-657. Notification of applicant following evaluation of application.**

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"**§ 90-658. License as property of the Board; display requirement; renewal; inactive status.**

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"**§ 90-660. Expenses; fees.**

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"**§ 90-661. Requirement of license.**

After October 1, 2002, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.
(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.
(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"**§ 90-662. Violation a misdemeanor.**

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.
(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.
(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.
(4) A person who performs only support activities as defined in G.S. 90-648(13).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 2000. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) must have passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public members appointed by the Governor shall be appointed for a one-year term; the

physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; the physician member appointed by the Old North State Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4.(a) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

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

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Credit.
b. Disability income.
c. Coverage issued as a supplement to liability insurance.
d. Hospital income or indemnity.
e. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
f. Long-term or nursing home care.
g. Medical payments under motor vehicle or homeowners' insurance policies.
h. Medicare supplement.
i. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
j. Workers' compensation.

(2) 'Claimant' includes 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.

(3) 'Health care facility' means a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(4) 'Health care provider' means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(5) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim.

(2) Notice of denial of the claim.
(3) Notice that the proof of loss is inadequate or incomplete.
(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
(5) Notice that coordination of benefits information is needed in order to pay the claim.
(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

(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 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 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 days after receiving the additional information.

(d) If an insurer requests additional information under subsection (c) of this section and the insurer does not receive the additional information within 90 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 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 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 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 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.

(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 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 days after the previous report was sent.

(h) To the extent permitted by the contract between the insurer and the health care provider or health care facility, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Recoveries by the insurer must be accompanied by the specific reason and adequate information to identify the specific claim. To the extent permitted by the contract between the insurer and the health care provider or health care facility, the health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may be specified in the contract between the insurer and health care provider or health care facility.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) This section does not apply to claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer:

(1) Verifies with the Commissioner that its claims adjudication system qualifies under this subsection; and

(2) Is implementing a new claims adjudication software system and is proceeding in good faith to move all claims to the new system as soon as possible and in any event no later than December 31, 2002.

This subsection expires January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses."

Section 4.(b) G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 4.(c) G.S. 58-3-172(a) reads as rewritten:

"(a) For all claims denied for health care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 4.(d) G.S. 58-51-15(a)(7) reads as rewritten:

"(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ~~90~~ 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within ~~90~~ 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal ~~capacity,~~ capacity of the insured, later than one year from the time proof is otherwise required."

Section 5. Section 4 of this act becomes effective July 1, 2001, and applies to claims received on or after that date. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 13th day of July, 2000.

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Marc Basnight
President Pro Tempore of the Senate

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James B. Black

Speaker of the House of Representatives

_____

James B. Hunt, Jr.
Governor

Approved _____.m. this _____ day of _____ , 2000