

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2003

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HOUSE DRH70079-LN-52 (2/27)

Short Title: Managed Care/Hlth Benefits Clarifying-AB.

(Public)

Sponsors: Representative Wright.

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 CAN 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 (g) read as rewritten:

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

...

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

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

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

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

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

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

23 ..."

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

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

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

34 "(f) Second-Level Grievance Review. – An insurer shall establish a second-level  
35 grievance review process for covered persons who are dissatisfied with the first-level  
36 grievance review decision or a utilization review appeal decision. A covered person or  
37 the covered person's provider acting on the covered person's behalf may submit a  
38 second-level grievance.

39 (1) An insurer shall, within 10 business days after receiving a request for a  
40 second-level grievance review, make known to the covered person:

- 41 a. The name, address, and telephone number of a person  
42 designated to coordinate the grievance review for the insurer.  
43 b. A statement of a covered person's rights, which include the  
44 right to request and receive from an insurer all information

1 relevant to the case; attend the second-level grievance review;  
2 present his or her case to the review panel; submit supporting  
3 materials before and at the review meeting; ask questions of any  
4 member of the review panel; and be assisted or represented by a  
5 person of his or her choice, which person may be without  
6 limitation to: a provider, family member, employer  
7 representative, or attorney. If the covered person chooses to be  
8 represented by an attorney, the insurer may also be represented  
9 by an attorney.

- 10 (2) An insurer shall convene a second-level grievance review panel  
11 consisting of one or more persons for each request. The panel shall  
12 comprise persons who were not previously involved in any matter  
13 giving rise to the second-level grievance, are not employees of the  
14 insurer or URO, and do not have a financial interest in the outcome of  
15 the review. A person who was previously involved in the matter may  
16 appear before the panel to present information or answer questions. All  
17 of the persons reviewing a second-level grievance involving a  
18 noncertification or a clinical issue shall be providers who have  
19 appropriate expertise, including at least one clinical peer. Provided,  
20 however, an insurer that uses a clinical peer on an appeal of a  
21 noncertification under G.S. 58-50-61 or on a first-level grievance  
22 review panel under this section may use one of the insurer's employees  
23 on the second-level grievance review panel in the same matter if the  
24 second-level grievance review panel comprises three or more persons."

25 **SECTION 4.** This act is effective when it becomes law.