March 1, 2001

H 351. UTILIZATION REVIEW AND GRIEVANCE CHANGES. *TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES*. Amends sections of GS Ch. 58 as title indicates. Substantive changes include tightening the definitions of "grievance" to exclude complaints based solely on noncertification of benefits that are clearly excluded in the certificate of coverage; counting notification of noncertification of benefits given to a health care provider of institutionalized insureds; expanded process and timing requirements for requests for reconsideration, appeals, and grievances; and confidentiality provisions for grievances. **Intro. by Hurley and Dockham.**

Ref. to Insurance	GS 58

April 23, 2001

H 351. UTILIZATION REVIEW AND GRIEVANCE CHANGES. Intro. 03/01/01. House committee substitute makes the following changes to 1st edition: (1) rewords GS 58-50-61(a)(13) to provide that a "noncertification" includes any situation in which an insurer or its designated agent makes a *decision* about a covered person's condition (was, "an evaluation or review of medical information"); (2) deletes proposed amendments to G.S. 58-50-61(f) (prospective and concurrent reviews) and to G.S. 58-50-61(l) that would have provided that when the covered person is institutionalized, a written notice of noncertification must be provided to the covered person, but that the noncertification is deemed to have been communicated to the covered person upon notification of the covered person's provider; (3) makes editorial changes to G.S. 58-50-61(k) and G.S. 58-50-61(e); (4) changes proposed G.S. 58-50-61(e) to provide that with respect to a first-level grievance review , the insurer must issue a written decision *in clear terms* and must include the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position regardless of whether the decision is in favor of the covered person; and (5) rewrites G.S. 58-50-62(e)(3) to provide that the insurer must acknowledge the grievance within 10 business days if the grievance concerns the quality of clinical care delivered by the provider and that the acknowledgement must advise the covered person that (a) the insurer must refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider, and (b) State law does not allow for a second-level grievance review for grievances concerning quality of care.

August 29, 2001

H 351. UTILIZATION REVIEW AND GRIEVANCE CHANGES. Intro. 3/1/01. Senate committee substitute makes the following changes to 2nd edition. Changes title to *AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES; TO CLARIFY THE DEFINITION OF "HEALTH CARE PROVIDER" IN THE PROMPT PAYMENT LAW; AND TO MAKE A CORRECTION IN THE DEFINITION OF HMO.* Amends the definition in GS 58-3-225(a)(4) to provide that health care provider includes individuals licensed under the laws of another state, and makes similar clarification in the definition in GS 58-50-61(a)(8) (utilization review). Amends GS 58-67-5(f) to change the definition of HMO to any person who undertakes to provide or arrange for the delivery of health care services (was, basic health care services).

September 25, 2001

SL 2001-417 (H 351). UTILIZATION REVIEW AND GRIEVANCE CHANGES. *AN ACT TO MAKE TECHNICAL AND SUBSTANTIVE CHANGES IN THE LAW GOVERNING MANAGED CARE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES; TO CLARIFY THE DEFINITION OF "HEALTH CARE PROVIDER" IN THE PROMPT PAYMENT LAW; AND TO MAKE A CORRECTION IN THE DEFINITION OF "HMO".* Summarized in *Daily Bulletin* 3/1/01, 4/23/01, and 8/29/01. Enacted Sept. 22, 2001. Effective Oct. 1, 2001.