February 22, 2001

S 218. MANAGED CARE ENTITY EXTERNAL REVIEW. *TO PROVIDE STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH BENEFIT PLAN COVERAGE DECISION MADE BY THE INSURER OR MANAGED CARE PLAN AND TO MAKE CONFORMING AMENDMENTS TO EXISTING LAWS ON UTILIZATION REVIEW AND GRIEVANCES.* Requires health insurance plans to establish and maintain procedures that allow for independent review of an appeal decision upholding a plan's noncertification decision or a second-level grievance review decision upholding a noncertification decision (a plan's decision not to pay for a health care service because the service does not meet the insurer's requirements for medical necessity, appropriateness, or health care setting, or because the plan has determined that the service is experimental, investigational, or cosmetic). Unlike S 21, does *not* include provisions making managed care entities liable for damages for harm resulting from the entities' negligent health care treatment decisions.

Establishes procedures, standards, and time frames for independent, external review of an appeal decision upholding a plan's noncertification decision or a second-level grievance review decision upholding a noncertification decision. Provides for expedited external review if the person covered by the plan ("covered person") has a medical condition where the time frame for completing an expedited second-level grievance review under GS 58-50-62 would seriously jeopardize the covered person's life or health or the covered person's ability to regain maximum function. Requires health insurance plans to give notice to covered persons of their right to request external review. Provides that a covered person must exhaust the plan's internal review procedures before seeking external review.

External reviews must adhere to the following procedures and time frames: A covered person must file a request for external review with the Comm'r of Insurance ("Comm'r") within 30 days of receipt of an appeal decision upholding a plan's noncertification decision or a second-level grievance review decision upholding a noncertification decision. Comm'r must complete a preliminary review of the request within five business days, determining whether: (1) the person was covered by the plan, (2) the decision in question is a noncertification, (3) the covered person has exhausted internal appeal and grievance procedures, and (4) the covered person has provided all information and forms necessary to an external review. Unless waived due to indigency, request for review must be accompanied by nonrefundable $25 fee. Request for review may be accompanied by new or additional information or supporting documentation.

Upon completion of preliminary review, Comm'r must immediately notify the covered person whether the request is complete and whether it has been accepted for external review. If the request is incomplete, the covered person has 14 days to provide information needed to complete it. If the request is accepted for external review, Comm'r must within two business days provide written notice to the insurer and inform covered person and insurer of name and contact information of independent review organization selected by Comm'r (via alphabetized rotation among approved independent review organizations) to conduct external review. Requires insurer to provide specified information to external review organization within seven business days. The external review organization then reviews all information and documents and other specified information, including medical records, health care provider recommendations, and the health plan's terms of coverage. External review organization must reach a decision and notify the covered person, the insurer, and the Comm'r within 45 days. Expedited reviews must be completed as expeditiously as the covered person's medical condition requires, but at least within four days after the date of receipt of request for expedited review. External review decisions are binding on the insurer. An external review decision upholding an insurer's noncertification decision may be used as an affirmative defense in any subsequent legal action related to a noncertification.

Requires Comm'r to approve at least three independent review organizations. Directs Comm'r to establish an application procedure for external review organizations that requires approved organizations to have, among other things: a quality assurance mechanism ensuring that statutory standards and time frames are met and reviewers are qualified and impartial, that external review organizations are not affiliated with a health benefit plan, and that reviewers do not

have professional, familial, or financial conflicts of interest. Comm'r may not approve application of independent review organization whose fees exceed commercially reasonable fees charged for similar services in the industry. Requires $500 application fee and $250 renewal fee.

Effective Oct. 1, 2002.

Intro. by Hoyle.

Ref. to Insurance	GS 58