GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2001

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SENATE BILL 218

Short Title:	Managed Care Entity External Review.	(Public)
Sponsors:	Senator Hoyle.	
Referred to:	Insurance and Consumer Protection.	

February 22, 2001

A BILL TO BE ENTITLED

AN ACT 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.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"Article 50.

"General Accident and Health Insurance Regulations."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

SECTION 3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

SECTION 4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

(a) Definitions. – As used in this ~~section and~~section, in G.S. 58-50-62, and in Part 4 of this Article, the term:".

SECTION 5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 4. Health Benefit Plan External Review.

"**§ 58-50-75. Purpose, scope, and definitions.**

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all persons that provide or perform utilization review, including the Teachers' and State Employees' Comprehensive Major Medical Benefit Plan and The Health Insurance Program for Children. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

(1) 'Covered benefits' or 'benefits' means those benefits consisting of medical care, including items and services paid for as medical care, under the terms of a health benefit plan.

(2) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions.

"**§ 58-50-76:** Reserved.

"**§ 58-50-77. Notice of right to external review.**

(a) In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its external review procedures, including the procedures for requesting nonexpedited and expedited external review and a statement of the rights and responsibilities of covered persons with respect to external review. The description shall include a statement that the external review process is voluntary and shall inform the covered person of the availability of the Commissioner's office to provide information and assistance, and the telephone number and office address of the Commissioner for filing external review requests. The description shall also include a statement informing the covered person that exhaustion of the external review process is required prior to exercising any other remedy available to the covered person.

(b) An insurer shall include notice of the right to external review and a brief description of its external review procedures in expedited first-level appeal decision letters notifying covered persons that a noncertification has been upheld and second-level grievance decision letters notifying covered persons that a noncertification has been upheld.

(c) In addition to the information to be provided under subsection (b) of this section, the insurer shall reference the relevant pages of the certificate of coverage or

applicable endorsement or rider to the certificate of coverage that contain the description of the insurer's external review procedures.

"**§ 58-50-78:** Reserved.

"**§ 58-50-79. Exhaustion of internal grievance process.**

(a) Except as provided in subsections (d) and (e) of this section, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

(1) Has fully completed the appeal and second-level grievance procedures under G.S. 58-50-61 and G.S. 58-50-62;

(2) Has fully completed the appeal process under G.S. 58-50-61 and has filed a request for a second-level grievance under G.S. 58-50-62 and, except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the insurer received the grievance request; or

(3) Has fully completed the appeal process under G.S. 58-50-61 and has been granted an expedited external review by the Commissioner, or if the insurer has been granted an expedited external review by the Commissioner.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal appeal and second-level grievance process.

(d) If the covered person has a medical condition where the time frame for completion of an expedited second-level grievance review under G.S. 58-50-62 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request with the Commissioner for an expedited external review under G.S. 58-50-82. An insurer may waive its right to conduct an expedited second-level grievance review of an appeal and allow the covered person to request an expedited external review of the noncertification.

(e) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement.

(f) If the requirement to exhaust the insurer's internal grievance procedures is waived under subsection (e) of this section, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80.

"**§ 58-50-80. Standard external review.**

(a) Within 30 days after the date of receipt of a notice of a noncertification appeal decision that includes the insurer's waiver of the second-level grievance review

process, or a second-level grievance review decision under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Within two business days of receipt of a request for an external review under subsection (a) of this section, the Commissioner shall notify and send a copy of the request, including the disclosure authorization form executed by the covered person, to the insurer that made the decision which is the subject of the request. Within two business days of receipt of this information from the Commissioner, the insurer shall submit to the Commissioner the information required for the preliminary review under subdivisions (1), (2), and (3) of subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to confirm that:

(1) The individual is a covered person under the health benefit plan at the time the health care service in question was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(2) The decision in question is a noncertification as defined under G.S. 58-50-61.

(3) The covered person has exhausted the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62, unless the covered person is not required to exhaust the insurer's internal grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review, including a copy of the notice provided under G.S. 58-50-77 and documentation that the health care service that will be the subject of the external review would, if not covered by the insurer, result in out-of-pocket expenses of five hundred dollars ($500.00) or more to the covered person and a form, signed by the covered person, authorizing the external review and the release of necessary information by the insurer.

(5) The request for review is accompanied by a certified check or money order for the nonrefundable twenty-five dollar ($25.00) filing fee or documentation of the covered person's indigence. The filing fee may be waived by the Commissioner only upon receipt of acceptable documentation of the covered person's indigence.

(6) The request for review is accompanied by any new or additional relevant information and/or supporting documentation to be considered by the organization when conducting the external review.

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review. Prior to accepting a complete request, the Commissioner shall determine whether the covered person has or will provide information not previously made available to the insurer

within one business day of its receipt. The Commissioner shall forward any such information to the insurer and shall delay acceptance of the request for external review to allow the insurer an opportunity to review the new information and reconsider its noncertification decision pursuant to subsection (k) of this section. The insurer's determination must be communicated to the Commissioner and the covered person within three business days of receipt of the new information from the Commissioner.

(e) If the request is accepted for external review, the Commissioner shall within two business days:

(1) Notify the insurer and the covered person in writing of the acceptance of the request for external review.

(2) Inform the covered person and the insurer of the name and contact information for the independent review organization selected by the Commission to conduct the external review.

(3) Send a copy of the request to the organization selected by the Commissioner to conduct the external review.

(f) If the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 14 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(g) The Commissioner shall maintain an alphabetical listing of independent review organizations approved under G.S. 58-50-85 to conduct external reviews and shall systemically assign on a rotating basis the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62, but shall, in all cases, be bound by the terms of the covered person's health benefit plan.

(h) Within seven business days after the date of receipt of the notice provided under subsection (e) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization a copy of the applicable sections of the covered person's health benefit plan certificate, evidence of coverage, policy, or insurance contract along with any other documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision. The insurer may also provide the organization with a written statement of the insurer's position in the matter. Except as provided in subsection (i) of this section, failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review.

(i) If the insurer or its utilization review organization has been provided with a written authorization signed by the covered person authorizing the disclosure of information relevant to the matter under review and fails to provide the documents and information within the time specified in subsection (h) of this section, the assigned organization may conduct the external review using information received from the Commissioner under subdivision (e)(3) of this section to make its decision. Upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(j) The assigned organization shall review all of the information and documents received under subsections (h) and (i) of this section and any other information submitted in writing by the covered person that has been forwarded to the organization by the Commissioner.

(k) Upon receipt of the information required to be forwarded under subsection (d) of this section, the insurer shall reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. If the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision, the matter shall no longer be eligible for external review.

(l) Within five business days of receipt of new information from the Commissioner which results in making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (k) of this section, the insurer shall notify the Commissioner in writing of its decision.

(m) The assigned organization's decisions shall not be contrary to and shall be consistent with (i) the terms of coverage under the covered person's health benefit plan with the insurer and (ii) the insurer's or the insurer's designee utilization review organization's documented clinical review criteria, in accordance with G.S. 58-50-61(d). In addition to the documents and information provided under subsection (h) of this section, the assigned organization, to the extent the documents or information are available and are not inconsistent with the requirements of this subsection, shall consider the following in reaching a decision:

(1) The covered person's medical records.

(2) Documentation submitted by the attending health care provider supporting the medical necessity and appropriateness of the requested health care service.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) Medical necessity, as defined in G.S. 58-3-200(b).

In the event the assigned organization determines that the clinical review criteria used in rendering the appeal or second-level grievance review decision upholding the original noncertification do not meet the requirements of G.S. 58-50-61(d), the assigned organization may consider alternate clinical review criteria that do comply with G.S. 58-

50-61(d) in reaching a decision. If alternate review criteria are used, the organization shall provide any such alternate review criteria and an explanation of why such criteria were substituted for the insurer's clinical review criteria in the notice sent under subsection (n) of this section.

(n) Within 45 days after the date of receipt by the Commissioner, the assigned organization shall provide written notice of its decision to uphold or reverse the insurer's noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, and the Commissioner.

(o) The organization shall include in the notice sent under subsection (n) of this section:

(1) A general description of the reason for the request for external review.

(2) The date the organization received the assignment from the Commissioner to conduct the external review.

(3) The date the organization received information and documents submitted by the covered person and by the insurer.

(4) The date the external review was conducted.

(5) The date of its decision.

(6) The principal reason or reasons for its decision.

(7) The clinical rationale for its decision.

(8) References to the evidence or documentation, including the clinical review criteria and applicable terms of coverage, supporting its decision.

(9) The professional qualifications and licensure of the clinical peer reviewers.

(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(p) Upon receipt of a notice of a decision under subsection (n) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer immediately shall approve the coverage that was the subject of the noncertification appeal decision or second-level grievance review decision.

"**§ 58-50-81:** Reserved.

"**§ 58-50-82. Expedited external review.**

(a) Except as provided in subsection (g) of this section, a covered person may make a request for an expedited external review with the Commissioner if the covered person meets any of the following requirements:

(1) The covered person has received a nonexpedited appeal decision upholding a noncertification, and the covered person has a medical condition where the time frame for completion of an expedited second-level grievance review under G.S. 58-50-62 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for expedited review accompanied by appropriate documentation of the covered person's medical condition and the information and material required under G.S. 58-50-80(c). The

Commissioner shall evaluate the clinical appropriateness of all such requests for expedited external review and decide whether or not they will be granted. If the request is not granted, the covered person must complete the standard or expedited second-level review procedure, as determined by the insurer in accordance with G.S. 58-50-62, before qualifying for an external review.

(2) If the covered person has received a nonexpedited second-level grievance decision upholding a noncertification and the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for expedited review accompanied by appropriate documentation of the covered person's medical condition and the information and material required under G.S. 58-50-80(c). The Commissioner shall evaluate the clinical appropriateness of all such requests for expedited external review and decide whether or not they will be granted, in addition to complying with all other requirements of this section. If the request is not granted, the Commissioner shall automatically treat the request as a request for a standard external grievance under G.S. 58-50-80.

(3) If the noncertification decision under review involves a concurrent review decision as defined under G.S. 58-50-61(a)(17)d., the covered person or the insurer may waive any internal review requirements and request that the Commissioner grant an expedited external review under G.S. 58-50-82. Any such request accompanied by the information and material required under G.S. 58-50-80(c) shall be granted by the Commissioner in accordance with the requirements of this section.

(b) If the covered person has received an expedited second-level grievance review decision upholding a noncertification or an expedited appeal decision upholding a noncertification, the covered person may file a request for an expedited external review. Any such request accompanied by the information and material required under G.S. 58-50-80(c) shall be granted by the Commissioner in accordance with the requirements of this section.

(c) At the time the Commissioner receives a request for an expedited external review, the Commissioner shall, within one business day of receipt of the request:

(1) For requests based on an assertion by the covered person that the time frames for a standardized review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, evaluate the supporting documentation submitted by the covered person and determine whether the request should be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S.

58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. Where a request for expedited review is granted, the Commissioner shall evaluate the completeness of the information and materials required under G.S. 58-50-80(c).

(2) Prior to accepting a request that meets the requirements of G.S. 58-50-80(c), the Commissioner shall determine whether the covered person has or will provide information not previously made available to the insurer. The Commissioner shall forward any such information to the insurer and shall delay acceptance of the request for expedited external review to allow the insurer an opportunity to review the new information and reconsider its noncertification decision pursuant to G.S. 58-50-80(k). The insurer's determination must be communicated to the Commissioner within two business days of receipt of the new information from the Commissioner. If the insurer decides, upon completion of its review, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance decision, the matter shall no longer be eligible for external review.

(3) For accepted requests for expedited review, the Commissioner shall assign, as provided under G.S. 58-50-80(g), an organization that has been approved under G.S. 58-50-87. The Commissioner shall then inform the covered person and insurer of its determination and external review organization assignment.

(d) In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62, but shall, in all cases, be bound by the terms of the covered person's health benefit plan.

(e) Within two business days of the insurer's receipt of the notice from the Commissioner under subsection (b) of this section, the insurer or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the final noncertification decision, including a copy of the covered person's health benefit plan certificate, evidence of coverage, policy, or insurance contract, to the assigned organization electronically or by telephone or facsimile or any other available expeditious method. The insurer may also provide the organization with a written statement of the insurer's position in the matter.

(f) The assigned organization's decisions shall not be contrary to and shall be consistent with (i) the terms of coverage under the covered person's health benefit plan with the insurer and (ii) the insurer's or the insurer's designee utilization review organization's documented clinical review criteria, in accordance with G.S. 58-50-61(d). In addition to the documents and information provided under G.S. 58-50-80(h), the assigned organization, to the extent the documents or information are available and not

inconsistent with the requirements of this subsection, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records.

(2) Documentation submitted by the attending health care provider supporting the medical necessity and appropriateness of the requested health care service.

(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.

(4) Medical necessity, as defined in G.S. 58-3-200(b).

In the event the assigned organization determines that the clinical review criteria used in rendering the appeal or second-level grievance review decision upholding the original noncertification do not meet the requirements of G.S. 58-50-61(d), the assigned organization may consider alternate clinical review criteria that do comply with G.S. 58-50-61(d) in reaching a decision. If alternate review criteria are used, the organization shall provide any such alternate review criteria and an explanation of why such criteria were substituted for the insurer's clinical review criteria in the notice sent under subsection (g) of this section.

(g) As expeditiously as the covered person's medical condition requires, but not more than four days after the date of receipt of the Commissioner's notice under G.S. 58-50-82(b), the assigned organization shall make a decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(h) If the notice provided under subsection (f) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt of notice of a decision under subsection (f) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall approve the coverage that was the subject of the noncertification.

(i) An expedited external review may not be provided for retrospective noncertifications.

"**§ 58-50-83:** Reserved.

"**§ 58-50-84. Binding nature of external review decision.**

(a) An external review decision is binding on the insurer.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law; however, any other remedy is not available to the covered person unless an external review decision is reached. An external review decision upholding the insurer's noncertification decision may be used as an affirmative defense in any subsequent legal action related to a noncertification.

(c) A covered person may not file a subsequent request for external review involving the same service for which the covered person has already received an external review decision under this Part.

"**§ 58-50-85. Approval of independent review organizations.**

(a) The Commissioner shall approve a minimum of three independent review organizations eligible to be assigned to conduct external review under this Part to ensure that each organization satisfies the minimum qualifications established under G.S. 58-50-87 and subsection (c) of this section. The Commissioner shall develop an application form for initial approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees which do not meet the guidelines established under this subsection.

(c) The Commissioner may, in his discretion, determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 and subsection (c) of this section will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) The Commissioner shall charge an application fee of five hundred dollars ($500.00) that the independent review organizations shall submit to the Commissioner with an application for approval and reapproval.

(e) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87. The Commissioner shall charge a fee of two hundred fifty dollars ($250.00) for renewals.

(f) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the Commissioner under subsection (g) of this section.

(g) The Commissioner shall at all times maintain and periodically update a list of at least three approved independent review organizations.

"**§ 58-50-86:** Reserved.

"**§ 58-50-87. Minimum qualifications for independent review organizations.**

(a) As a condition of approval under G.S. 58-50-85 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

b. The selection of qualified and impartial clinical peer reviewers without material conflicts of interest with the insurer, covered person, or service provider(s), to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

c. The confidentiality of medical and treatment records and clinical review criteria.

d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.

(2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.

(3) If the covered person's treating provider is a medical doctor, holds a nonrestricted license from a state of the United States, and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(4) If the covered person's treating provider is not a medical doctor, holds a nonrestricted license, registration, or certification from a state of the

United States in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review or the regulatory agency authorized to oversee the external review process.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

(f) Nothing in this section shall be construed to prohibit an individual who furnishes health care items or services to a participant or beneficiary of a group health plan under a contract or other arrangement with the plan or insurer to also serve as an independent review organization or clinical peer reviewer, provided that the reviewer was not involved with the specific claim being reviewed.

"**§ 58-50-88**: Reserved.

"**§ 58-50-89. Hold harmless for independent review organizations.**

No independent review organization or clinical peer reviewer working on behalf of an organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

"**§ 58-50-90. External review reporting requirements.**

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review shall submit to the Commissioner, at least annually, a report in the format specified by the Commissioner.

(c) The report shall include in the aggregate and for each insurer:

(1) The total number of requests for external review.

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.

(3) The average length of time for resolution.

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner.

(5) The number of external reviews under G.S. 58-50-80(k) and (l) that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.

(d) The organization shall retain the written records required under this section for at least three years.

(e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years.

"**§ 58-50-91:** Reserved.

"**§ 58-50-92. Funding of external review.**

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 58-50-93. Disclosure requirements.**

(a) Each insurer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of a noncertification appeal decision or a second-level grievance review decision upholding a noncertification in accordance with this Part with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records or other personal information of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review, and that such authorization is required in order to be eligible for external review.

"**§ 58-50-94. Competitive selection of independent review organizations.**

(a) The Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the costs and quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall contract with a minimum of three review organizations and shall ensure that at least two of the selected review organizations are available to and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this

section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part.

"**§ 58-50-95. Report by Commissioner.**

The Commissioner shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report should include the number of reviews, character of the reviews, dollar amounts in question, and any other information relevant to the evaluation of the effectiveness of this Part."

SECTION 6. G.S. 58-50-61(a)(13) reads as rewritten:

"(13) 'Noncertification' means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A 'noncertification' is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A 'noncertification' includes any situation in which an insurer or its designated agent makes an evaluation or review of medical information about a covered person's condition to determine whether a requested treatment is experimental or investigational and the extent to which coverage under the health benefit plan is affected by that decision."

SECTION 7. G.S. 58-50-61(a)(17)g. reads as rewritten:

"g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met."

SECTION 8. This act becomes effective October 1, 2001.