GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S **D**

SENATE DRS85140-LN-140A* (3/9)

Short Title:	Improve Managed Care Statutes.-AB	(Public)
Sponsors:	Senator Thomas.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REMOVE FROM THE UNIFORM CREDENTIALING STATUTE AN UNNECESSARY PROVISION; CLARIFY THAT SERVICES COVERED ONLY FOR CERTAIN MEDICAL CONDITIONS OR DIAGNOSES MUST BE TREATED AS UTILIZATION REVIEW DECISIONS WHEN IT IS NECESSARY TO REVIEW THE COVERED PERSON'S CONDITION OR DIAGNOSIS IN ORDER TO DETERMINE IF THE SERVICE IS EXCLUDED OR COVERED; ENSURE THAT COVERED PERSONS RECEIVING EXTERNAL REVIEW KNOW WHAT INFORMATION THEIR INSURER PROVIDES TO THE EXTERNAL REVIEW ORGANIZATION PERFORMING THE REVIEW; AND ELIMINATE EXTERNAL REVIEW OUTSIDE OF NORMAL BUSINESS HOURS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230(a) reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

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

SECTION 2. G.S. 58-50-61(a)(13) reads as rewritten:

"**§ 58-50-61. Utilization review.**

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

…

(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.~~coverage, and a decision about a covered person's condition is not necessary to determine whether the requested service is excluded. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is excluded, experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision."

SECTION 3.(a) G.S. 58-50-80(b)(4) reads as rewritten:

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

…

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

…

(4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned ~~organization,~~organization and to the covered person or authorized representative who made the request for external review on behalf of the covered person, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision."

SECTION 3.(b) G.S. 58-50-82(c) reads as rewritten:

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

…

(c) As soon as possible, but within the same day of receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available

expeditious method. A copy of the same information shall be sent by the same means or other expeditious means to the covered person or the covered person's representative who made the request for expedited external review."

SECTION 4. The first sentence of G.S. 58-50-82(b) reads as rewritten:

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

…

(b) Within three business days of receiving a request for an expedited external review, the Commissioner shall complete all of the following:".

SECTION 5. G.S. 58-50-82(e) reads as rewritten:

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

…

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than four business days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. 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."

SECTION 6. This act becomes effective October 1, 2005, and applies to policies or certificates issued or renewed on or after that date.