

North Carolina Medical Society



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# North Carolina Physician Managed Care Contracting Toolkit

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NORTH CAROLINA  
PHYSICIAN MANAGED CARE  
CONTRACTING TOOLKIT

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# I. Summary of Statutes and Regulations Impacting Physician/Health Plan Contracting

## A. Summary: Prompt Pay Statute and Associated NCDOI Guidance (*NCGS §58-3-225: Prompt claim payments under health benefit plans; NCDOI Guidance*)

### Applicability

- Applies to HMOs, PPOs, North Carolina-Licensed Insurers, MEWAs, State Employee Health Plan
- Does not apply to Self-Insured Employers, Medicaid, Medicare, Workers' Compensation
- Prompt Pay Law Applies Only to Insurer Payment to Intermediaries (IPAs); Not to IPA's Subsequent Payments to Providers
- NC Department of Insurance Prompt Pay Guidance (Updated April 27, 2001): Further Guidance on Law
- US Department of Labor Rules: Apply to Self-Insured Employers

### General Rules

- Requires Payment, Notice(s) or Denial within 30 Calendar Days after Receipt of Claim
- Mailbox Rule: Receipt Five Business Days after Mailed or Date of Electronic Transmission is Presumed
- No Less Than 180 Days to Submit Claims Regardless of Contract Language Unless...
- If "Not Reasonably Possible" to Submit Claim: Then = 1 Year + 180 Days

### Payment Rules

- Payment Assumption: Date Placed in Mail or Date of Electronic Funds Transfer
- Law Does Not Require Remittance Advice and Check Be Sent Together
- Grievance/Appeal: Payment Clock Starts on Date of Decision

### Notices

- Notice/Denial: *List All Good Faith Reasons*
- Notice/Need Additional Information: *List All Needed Information*
- Notice/Wrong Form: *Include Correct Form*
- Notice/COB Information: *No Timeframe--but if Denied, Physician Can Bill Patient*

- Notice/Pended for Nonpayment of Premiums: *30-Day Lapse in Coverage*
- Notice/Medical Necessity Criteria: *Include Specific Clinical Rationale*

Additional Information Needed

- Health Plan to Pay Claim within 30 Days of Receipt of Additional Information
- If Additional Information not Received: Health Plan May Deny Claim after 90 Days from Request (One Year + 90 Days to Refile)
- If Additional Information Insufficient: Refile within 180 Days of Date of Service

Interest Payments

- 18% Interest Begins to Accrue on the 31st Day
- Interest Automatically Paid by Health Plan
- Partial Payment Results in Interest on Remainder
- Provider Not Required to Pay Interest on Overpayments (unless Required by Contract) However...
- Interest must be Paid Back if Recoupment
- Insurer must Report Interest Information on each Claim to Demonstrate Compliance

B. Summary: Prompt Pay Statute--Recoupment Limitation  
(*NCGS § 58-3-225: Prompt claim payments under health benefit plans*)

- Insurer to notify provider in writing not less than 30 calendar days before seeking overpayment recovery or offsets of future patients
- Notice to be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery
- Recovery of overpayments or offsetting of future payments not permitted more than two years after the date of the original claim payment unless insurer has reasonable belief of fraud or other intentional misconduct, or if the claim involves a health care provider or health care facility receiving payment for the same service from a government payor.

C. Summary: Credentialing Statute and Rules (*NCGS §58-3-230: Uniform Provider Credentialing, NCAC 20.0401-20.0410*)

- Requires assessment/verification within 60 days of completed application.



- Effective date of new physician = Date of approval
- Uniform Credentialing Application: No additional information may be required
- Recredentialing can be abbreviated version in same order as Uniform Credentialing Application
- Regulations govern credentialing process (11 NCAC 20.0404 and 11 NCAC 20.0405)
  - ✦ Require health plan program, organizational structure, verification plan
  - ✦ Lists elements of the application itself
  - ✦ Specifies timeframes and notice requirements
  - ✦ Outlines reverification process
  - ✦ Describes delegation activities
  - ✦ Requires termination, suspension process

D. Summary: North Carolina Disclosure Statute (NCGS §58-3-227: Health plan fee schedules)

- Insurers to Give Providers Top 30 codes plus Remainder on Request (at least annually)
- Limited to Codes "Commonly Billed by that Class of Provider"
- At least 30 Days Advance Notice (or Contracted Notice Period if Shorter) Prior to Fee Schedule Changes
- At least 30 Days Advance Notice (or Contracted Notice Period if Shorter) Prior to Reimbursement Policy Changes
- At least 30 Days Advance Notice (or Contracted Notice Period if Shorter) Prior to Claims Submission Policy Changes
- Fee Schedule Disclosure Requirements are also Applicable to "Providers Offered a Contract" by an Insurer
- Insurer May Provide "Reference Information"
- "Reimbursement Policies" defined as:
  - ✦ Policies on claims bundling and other claims editing processes
  - ✦ Policies on recognition or non-recognition of CPT code modifiers
  - ✦ Policies on downcoding of services or procedures
  - ✦ Definitions of global surgery periods
  - ✦ Policies on multiple surgical procedures
  - ✦ Policies related to payment based on the relationship of procedure code to diagnosis code

E. Summary: North Carolina Patient Bill of Rights (Selected Provisions)  
*NCGS §58-67-88: Continuity of Care; NCGS §58-3-223: Managed Care Access to Specialist Care; NCGS §58-3-235: Selection of Specialist as Primary Care Provider; NCGS §58-3-240: Direct Access*

*to Pediatrician for Minors; NCGS §58-3-221: Access to Non-Formulary and Restricted Access Prescription Drugs; NCGS §143-730: Managed Care Patient Assistance Program; NCGS §58-50-30: Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant; NCGS §58-3-191: Managed Care Reporting and Disclosure Requirements; NCGS §58-3-245: Provider Directories; NCGS §58-3-250: Payment Obligation for Covered Services; NCGS §58-3-255: Coverage of Clinical Trials; NCGS §58-3-265: Prohibition on Managed Care Provider Incentives*

- Continuity of Care Provisions
  - ✦ HMO Only
  - ✦ Patients can elect to continue to receive care upon contract termination if services are for an ongoing special condition
  - ✦ 90 Days Transitional Period for Scheduled Surgery, Organ Transplantation or Inpatient Care
  - ✦ Second Trimester for Pregnancy
  - ✦ Until End of Life for Termination Conditions
  - ✦ Fee Schedule Applicable at Termination Apply
  
- Extended or Standing Referral to a Specialist
  - ✦ Health plan must provide extended or standing referral to specialists for patients with certain conditions.
  
- Selection of Specialist as Primary Care Physician
  - ✦ Health plan must permit primary care physicians to act as specialist for patients with certain conditions.
  
- Direct Access to Pediatrician
  - ✦ Health plan must permit pediatricians to act as primary care physicians.
  
- Access to Non-Formulary Prescription Drugs
  - ✦ Health plans must develop any formulary with consultation of a pharmacy and therapeutic committee, must publish the formulary, and maintain a process that permits medically necessary drugs to be available without prior approval on an exception basis.

- Managed Care Patient Assistance Program
  - ✦ Establishes Managed Care Patient Assistance Program in agency designated by the Governor with specified duties.
  
- No Discrimination in the Selection of Providers
  - ✦ Patients/insured are entitled to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant (within their scope of practice) subject to HMO/PPO network requirements.
  
- Managed Care Reporting and Disclosure Requirements
  - ✦ Health plans required to file reports re: grievances, termination of coverage, termination of provider agreements, data relating to the utilization, quality, availability and accessibility of services, aggregate financial data and other information/data with the Department of Insurance on an annual basis.
  
- Provider Directory Information
  - ✦ Health plan to maintain provider directory updated at least annually.
  - ✦ Specific "network information" shall be listed
  - ✦ Allied health professionals listed upon receipt of certification.
  
- Disclosure of Payment Obligations
  - ✦ If patient payment is not a fixed dollar copay, health plan must explain methodology
  - ✦ Coinsurance amounts must be explained
  
- Mandated Benefits: Clinical Trials
  - ✦ Phase II, III and IV clinical trials are covered under certain criteria.
  - ✦ Only services required by the trials that have not been funded by other sources are covered.
  - ✦ Costs related to data collection, investigational drugs and devices and not provided for direct clinical management of the patient are not covered.
  
- Prohibition on Managed Care Provider Incentives
  - ✦ Insurers may not pay material inducement, bonus or other financial incentive to a provider to withhold or limit medically necessary health care services.
  - ✦ This does not include capitation or bonus payments, which are permitted.

- Independent External Review
  - ✦ Establishes external review program and procedures providing patients with an independent review of an appeal decision
  - ✦ Requires exhaustion of internal grievance process prior to requesting external review.
  - ✦ Provides for both standard and expedited reviews.
  - ✦ Establishes criteria for independent review organizations.
  
- Managed Care Entity Liability
  - ✦ Establishes managed care liability for health benefit plans.
  - ✦ Requires exercise of ordinary care and liability for damages for harm.
  - ✦ Managed care entities not liable for independent actions of health care providers.
  - ✦ Ordinary care defined as “the degree of care that, under the same or similar circumstances, a managed care entity of ordinary prudence would have used at the time the managed care entity made the health care decision.”

F. Summary: Prudent Layperson Statute (*NCGS §58-3-190: Coverage required for emergency care*)

- ✦ Insurers shall provide coverage for emergency services to the extent necessary to screen and stabilize the person and shall not require prior authorization.
- ✦ Must be covered if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.
- ✦ Insurers shall not impose cost sharing for non-participating emergency providers.

G. Summary: North Carolina Definition of Medical Necessity and Coverage/Network Provisions (*NCGS §58-3-200: Miscellaneous insurance and managed care coverage and network provisions*)

- ✦ North Carolina definition of medical necessity must be used by insurers that limit health benefit plan coverage to medically necessary services and supplies.
- ✦ Medically necessary defined as:
  - (1) “Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes”.
  - (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

- (3) Within generally accepted standards of medical care in the community.
- (4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

- ✦ If insurer determines services, supplies or other items are covered, the insurer is not permitted to subsequently retract its determination or reduce payments unless the determination is based on a material misrepresentation.

H. Summary: North Carolina Department of Insurance Bulletin No. 02-B-6: *Applicability of NCGS §58-3-200(d) in the enforcement of anti-assignment clauses in insurance contracts*

- ✦ Bulletin provides NC Department of Insurance interpretation of statute prohibiting penalizing or subjecting insureds to out-of-network benefit levels when an insured receives covered services from a non-participating provider because a participating provider was not reasonably available without unreasonable delay.
- ✦ Insurers are required to establish compliance mechanisms by August 23, 2002.

I. Summary: Utilization Review Statutes (*NCGS §58-50-61: Utilization review and NCGS §58-50-62: Insurance grievance procedures*)

- ✦ General statutes governing health benefit plan utilization review programs.
- ✦ Requires grievance process for insured's grievances, claims payment issues, contract issues and appeals of non-certifications.
- ✦ Requires health plans to document utilization review program process including both delegated and non-delegated functions.
- ✦ Requires use of documented clinical review criteria based on "sound clinical evidence."
- ✦ Requires medical doctor licensed in North Carolina to issue all non-certifications.
- ✦ Prohibits compensation of utilization reviewers from being based directly or indirectly on non-certifications of utilization review decisions.
- ✦ Defines specifications for prospective, concurrent and retrospective reviews.

- ✦ Permits process for requests of informal reconsiderations.
  - ✦ Requires appeal process for non-certifications, including both expedited and non-expedited processes.
  - ✦ Establishes detailed grievance process for patient grievances, including first and second level review procedures.
- J. Summary: Silent PPO Statute (*NCGS §58-63-70: Health care service discount practices by insurers and service corporations.*)
- ✦ Defines intentional misrepresentation to a health care provider that an insurer or service corporation is entitled to a discount off fees as an "unfair trade practice."
- K. Summary: Standard Insurance Identification Card Statute (*NCGS §58-3-247: Insurance identification card*)
- ✦ Insurers to provide an insurance identification card with identifiable, legible and pre-printed information.
  - ✦ The card must contain at a minimum:
    - Subscriber's name and identification number
    - Member's name and identification number
    - The group number
    - The name of the organization issuing the policy, the name of the organization administering the policy, and the name of the network, whichever applies
    - The effective date of health benefits plan coverage or the date the card is issued if it is after the effective date
    - Claims filing address and electronic claims filing payor identification number (if applicable)
    - Policyholder's obligations with regard to co-payments, if applicable, for at least the following visits: Primary care office, Specialty care office, Urgent care, Emergency room
    - The phone number or Web site address whereby the subscriber, member, or service provider, in compliance with privacy rules under the HIPAA may readily obtain the following:
      - Confirmation of eligibility
      - Benefits verification
      - Prior authorization for services and procedures
      - The list of participating providers in the network
      - The employer group number
      - Any special mental health medical benefits

- ✦ If the card is photocopied or electronically scanned, the resulting image must be clearly legible.
  - ✦ The identification card must present the information in a readily identifiable manner or the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.
- L. Summary: North Carolina Department of Insurance Contract Regulations re: Provider Contracts (*11 NCAC 20.0202*) including contracts with Intermediaries (*11 NCAC 20.0204*) and NCDOI Provider/Intermediary Contract Compliance Checklist 10/1/2005): <http://www.ncdoi.com/LH/Documents/Checklists/ProviderIntermediary.xls>
- Establishes specific requirements for health plan provider standard contracts (called "contract forms"). Requirements include:
    - Term of the Contract
    - Insurance/Managed Care Term Definitions
    - Termination and Grounds for Termination
    - Continuing Obligations after HMO Insolvency or Provider Contract Termination
      - ✦ Transition of duties and records
      - ✦ Continuation of care (patient ready for discharge)
    - Licensure/Credentialing/Malpractice Insurance Requirements
    - Patient billing requirements including prohibition on billing for HMO members except coinsurance, copayments and deductibles
    - Call coverage requirements, if any
    - Mechanisms for verification of member eligibility
    - Patient records requirements
    - Cooperation with member grievance procedures
    - Nondiscrimination requirements
    - Assignment and delegation notification requirements
    - Dispute resolution processes
    - Data and reporting requirements
    - Provider payments including methodology
    - Compliance with utilization review/credentialing/quality and provider sanctions programs except no interference with ethical obligations or communication
    - Contract Execution Date (Preferred)
    - Assignment of Duties (no transfer by provider)
    - On-Call Coverage, if any

- Cooperation with Members re: Grievances
- Anti-Discrimination (health status)
- Verification of Eligibility Mechanism
- Carrier Reporting to Provider
- Listing in Provider Directory
- Medical Records Provisions including Copies to Carrier
- Member Billing--provider shall not bill member except for coinsurance, copayments, deductibles, non-covered services (HMO ONLY)
- Payment Methodology
- Compliance with Prompt Pay Statute
- "Intermediary Contracts:
  - Carrier contracts with intermediaries must be filed
  - Underlying intermediary contracts with providers must comply with all statutory and regulatory requirements
  - Carrier must monitor intermediary including contracts and financial condition

M. Summary: Statutes related to Insurers, Preferred Provider Organizations and Preferred Provider Benefit Plans (*NCGS §58-50-56*)

- Preferred provider contracts must be approved by the Commissioner of Insurance
- Providers must be able to submit applications for participation within 30 days of an initial offering
- Insurers must make information available to health care providers regarding insurance products
- Rules may be adopted regarding accessibility, adequacy of number and locations, availability of services and financial solvency
- Summary data to be provided to the Commissioner of Insurance

N. Statutes re: State Employee Health Plan (*NCGS Chapter 135: Retirement System for Teachers and State Employees; Social Security; Health Insurance Program for Children*)



## II. Applicability of Statutes to Health Plans

### 58-3-167. Applicability of acts of the General Assembly to health benefit plans.

(a) As used in this section:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any of the following kinds of insurance:

- a. Accident.
- b. Credit.
- c. Disability income.
- d. Long-term or nursing home care.
- e. Medicare supplement.
- f. Specified disease.
- g. Dental or vision.
- h. Coverage issued as a supplement to liability insurance.
- i. Workers' compensation.
- j. Medical payments under automobile or homeowners.
- k. Hospital income or indemnity.
- l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of

this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

- (b) Whenever a law is enacted by the General Assembly on or after October 1, 1999 that applies to a health benefit plan, the term "health benefit plan" shall be defined for purposes of that law as provided in subsection (a) of this section unless that law provides a different definition or otherwise expressly provides that the definition in this section is not applicable.
- (c) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. (1999-294, s. 5; 1999-456, s. 16.)

# Attachments

<u>Attachment A-1:</u>	Prompt Pay Statute
<u>Attachment A-2:</u>	North Carolina Department of Insurance Prompt Pay Guidance
<u>Attachment B:</u>	Prompt Pay Statute-Recoupment
<u>Attachment C-1:</u>	Credentialing Statute
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<u>Attachment N:</u>	Statutes re: State Employee Health Plan

## **Attachment A-1: Prompt Pay Statute**

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

- (a) As used in this section:
  - (1) "Claimant" includes 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.
  - (2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
    - a. Credit.
    - b. Disability income.
    - c. Coverage issued as a supplement to liability insurance.
    - d. Hospital income or indemnity.
    - e. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
    - f. Long-term or nursing home care.
    - g. Medical payments under motor vehicle or homeowners' insurance policies.
    - h. Medicare supplement.
    - i. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
    - j. Workers' compensation.
  - (3) "Health care facility" means a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

- (4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.
- (5) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

- (1) Payment of the claim.
- (2) Notice of denial of the claim.
- (3) Notice that the proof of loss is inadequate or incomplete.
- (4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
- (5) Notice that coordination of benefits information is needed in order to pay the claim.
- (6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a

notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

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

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in

which claims may be submitted to fewer than 180 days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

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

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments may be made not more than two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may not exceed two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid,

denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) Expired January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses. (2000-162, s. 4(a); 2001-417, s. 1; 2007-362, s. 1.)



# Attachment A-2: North Carolina Department of Insurance Prompt Pay Guidance

## NORTH CAROLINA DEPARTMENT OF INSURANCE PROMPT PAY GUIDANCE

**\*\* Updated April 27, 2001 \*\***

### SECTION I. QUESTIONS AS OF FEBRUARY 21, 2001

#### **1. What is the definition of “claimant”? Does “claimant” include the insured?**

A “claimant” is any person who files a claim for services, including the insured who received the services or the provider of the services. Such claim is applicable to incurred expenses covered by the insured’s insurance carrier. The claimant’s obligations with respect to claim filing procedures must be followed as stated in the provider contract or in the insured’s group policy or evidence of coverage. *[Refer to G.S. 58-3-225(a)]*

#### **2. With respect to an insurer’s obligation to investigate and take action on a claim within 30 days of receipt, when does the 30 day period begin?**

The 30 day period is calculated from the day a claim is received by the insurer or the insurer’s claims processor or clearinghouse. There is a statutory presumption that, without evidence to the contrary, the date of receipt is either the day the claim is transmitted electronically, or the fifth business day after it is placed in the U.S. mail. The 30 day time period for taking action on the claim is calculated from the presumed date of receipt, unless the insurer can prove a different date of receipt. *[Refer to G.S. 58-3-225(b)]* When a provider submits claims through a billing organization, the date the claim is submitted by the billing organization to the insurer is the date from which the presumed receipt date is calculated. If the provider’s billing organization is also the insurer’s claims processor, the 30 day period begins when the claim is received by the claims processing center of the organization. Since receipt date will be established based upon the date of mailing or electronic submission, it will be incumbent upon health care providers and/or their billing organizations to document the date claims are mailed or electronically transmitted to the insurer or the insurer’s claims processor. Such documentation will be vital in resolving disputes regarding claim payment processing times.

#### **3. What constitutes sufficient evidence for rebuttal of the presumed date of receipt of a claim?**

The statute establishes a presumption that a claim is received by the insurer five business days after it is placed in the U.S. mail, or on the day it is transmitted electronically to the insurer’s designated clearinghouse. The Department anticipates that in most instances it will be very difficult, if not impossible, for an insurer to successfully rebut this presumption, especially when it contends the claim was never received. Some examples of evidence that a claim was not received at all, or was not received on the presumed date, might include the following *(These are examples only and are not assumed to provide sufficient evidence to rebut the presumption in all cases)*:

- ✦ The envelope accompanying the claim is clearly postmarked after the date the claim was presumed to have been received.
- ✦ The envelope accompanying the claim shows evidence of an incorrect or incomplete mailing address or insufficient postage.
- ✦ The provider utilizes a billing service that is unable to substantiate either that a claim was submitted at all, or the date that it was submitted to the insurer.
- ✦ Proof that the U.S. mail was not delivered on the date the claim was presumed to have been received.
- ✦ Information on the claim itself or accompanying the claim, indicating that it could not have been submitted on the presumed date.

In addition to the examples above, an insurer's date stamps, logs, or the verifiable mail room and claims handling procedures may provide sufficient evidence of the general claims handling practices of the insurer, but may or may not suffice as evidence of the receipt or non-receipt of an individual claim. The Department expects that providers and insurers will exercise reasonable judgment in resolving individual cases. In cases involving Department review, the parties should generally expect a high standard of proof will be necessary to establish an insurer's legitimate rebuttal of the presumed date a claim was received. In conjunction with that expectation, claimants will be expected to present reasonable evidence of the date the claim was mailed, transmitted electronically or otherwise delivered to the insurer.

The Managed Care and Health Benefits Division is considering development of a "Prompt Pay Complaint Form" for health care providers to use when they wish to file a complaint with the Department.

**4. When is payment considered to have been made?**

Payment is considered made on the date it is placed in the U.S. mail, or on the date of electronic transfer or other delivery of funds to the claimant. The Department recognizes that the date a check is written may not be the date of payment, as defined in the statute. In order to show compliance with this law, insurers will be required to maintain a record of the date of mailing or electronic transfer of funds. *[Refer to G.S. 58-3-225(e)]*

**5. Must the explanation of payment or Remittance Advice (RA) be mailed along with the claim payment?**

When the claimant is the insured, G.S. 58-63-15(11)(j) requires that payment of a claim be accompanied by a statement setting forth the coverage under which payment is being made. The law does not establish any requirement with respect to whether the payment and the RA must be sent together when the claimant is a provider.

**6. When an insurer is contracting with an intermediary, does the insurer's payment to the intermediary satisfy the law if it is made within statutory time frames, regardless of when the actual provider is paid?**

When an insurer contracts with an intermediary that is acting as the provider's agent, and the contract calls for payments to be made to the intermediary, the statutory time frames apply only to the insurer's payment to the intermediary. The timing of subsequent payment by the intermediary to the provider is not subject to the prompt pay law.

**7. When a claimant inquires about a claim older than 30 days, for which no payment, denial, or request for additional information has been received, will the insurer be required to acknowledge the inquiry in writing?**

The law does not require written acknowledgment of such inquiries, however both the insurer and the claimant are strongly advised to maintain written documentation of such communications\*, in the event that one or both parties wishes to seek the Department's review of a matter. Claimants who follow their telephoned inquiries to insurers with written confirmation of the call, will have established documentation, regardless of whether the insurer responds to the inquiry in writing. Any potential action or investigation by the Department of complaints regarding the prompt pay law will largely depend upon a written or electronic record of the matter in question.

*\* Note that while insurers are not required to acknowledge provider inquiries, they are subject to the requirement of G.S. 58-3-225(i), which calls for insurers to maintain written or electronic records sufficient to demonstrate compliance with the law.*

**8. How will the 30 day claims processing time standard apply to claims resulting from appeals and grievances?**

If an appeal or grievance decision results in the insurer reversing its denial of a claim, the 30 day time period for processing the claim would begin from the date of the appeal or grievance decision.

**9. If the provider contract calls for something other than a 180 day limit for submitting claim information, does the contract have to be amended, or does the law supersede the contract?**

As of July 1, 2001, insurers must be in operational compliance with the law, including the 180 day minimum time period for submitting claims set out in G.S. 58-3-225(f), regardless of existing contract language. In-force provider contracts that are more restrictive (allow less than 180 days) than the law will be superseded by the law. In-force provider contracts that are less restrictive (allow more than 180 days) than the law will remain in effect unless amended. New provider contracts executed on or after July 1, 2001 must be compliant with the prompt pay law. A contract that allows more than 180 days to submit claims is compliant with the law. Amendments regarding claims submission time frames are not considered to be "material" modifications to provider contracts, pursuant to 11 NCAC 20.0203, and therefore are not subject to Department approval. However, if/when an insurer makes a material modification to a contract, it must also make any necessary modifications to comply with the prompt pay law at that time, including changing the time to submit the claim to at least 180 days.

**10. Are there cases when a claimant would be permitted to file a claim in more than 180 days (or longer than the contractually allowed time, if that is more than 180 days)?**

**\*\*\* SEE CORRECTION LISTED IN SECTION II OF THIS DOCUMENT \*\*\***

G.S. 58-3-225(f) provides that unless otherwise agreed to by the insurer and the claimant, insurers must allow a claim to be submitted up to one year after the required date of submission (i.e., 180 days after the date of service or discharge plus one year), if it was not reasonably possible for the claim to be submitted within 180 days, and if the claim was submitted as soon as possible thereafter. Force majeure is assumed to be the standard for a provider's reasonable inability to file a claim within the established time frame, though contracts may include provisions establishing more generous standards. When the claimant is the insured, legal incapacity could extend the filing time beyond the one year extension. *[Refer to G.S. 58-3-225(f)]*

**11. May insurers pend or deny claims for lack of coordination of benefits (COB) information?**

G.S. 58-3-225(b)(5) clearly allows insurers to obtain COB information prior to paying a claim. An insurer is not obligated to make a payment to the provider or insured until it has established its liability, and COB information can be material to that determination. Insurers routinely verify third party coverage at the time a claim is filed since such coverage can change at any time, without any notice to the insurer.

**12. What are "good faith" reasons for denying claims and what standards can insurers impose for completeness and accuracy of claims? Can insurers correct or complete the submissions rather than requiring the claimant to do so?**

An insurer is not obligated to pay a claim until it has determined satisfactory proof of loss and this fact is not changed by the prompt pay law. The law does require insurers to be very explicit in their requests for additional information, however, their right to request that information is not altered. All of the specific good faith reasons for denial must be reflected in the notice of denial or request for additional information. In cases where the claimant provides additional information but the information is insufficient or incorrect, the insurer may deny the claim, again itemizing the information lacking. *[Refer to G.S. 58-3-225(b), (c) and (d)]* Since this law does not attempt to define "clean claim", the Department is not in a position to itemize information that may not be required in accordance with an insurer's standard claim practices. Each insurer must comply with the uniform claim form requirement of 11 NCAC 12.1500 and the electronic format standards requirements of 11 NCAC 12.1506. In addition, required attachments to claim forms are permitted, however, the form and format must be approved by the Department and insurers may not require the submission of information already contained in the standard claim form. Finally, under federal HIPPA regulations, currently scheduled to become effective January 1, 2003, an insurer is prohibited from altering the form on which the original claim was submitted.

Consequently, insurers will not be permitted to correct or supply information to the original form once those regulations are in effect.

**13. When a claimant submits additional information at the request of the insurer, and the additional information is incorrect or leads to further questions, can the insurer make a second request for additional information?**

The law requires that a claim shall be paid, denied or additional information requested within 30 days after it is received. Within 30 days after receiving additional information, the insurer shall continue processing the claim and either pay or deny the claim. *[Refer to G.S. 58-3-225(c)]* If the additional information requested by the insurer is not sufficient for the insurer to establish proof of loss, the insurer must deny the claim and include in the notice all of the good faith reasons for denial. If the claimant subsequently resubmits the claim with the necessary information, within 180 days of the date of service, the insurer shall reopen the claim. *[Refer to G.S. 58-3-225(f)]* A claim must be closed if additional information has been requested but is not received within 90 days of the request. In that instance, G.S. 58-3-225(d) provides that the notice to the claimant must specify that the claim will be reopened if the information previously requested is submitted within one year of the denial notice closing the claim.

**14. If an insurer knows in advance that it cannot meet the 30-day claims processing requirement (e.g., during periods of heavy claims volume), and notices are sent to claimants, advising of the expected delay and assuring payment with appropriate interest, will this be viewed by the Department as a “good faith” attempt to comply with the law?**

No. When an insurer can anticipate heavy claims volume at certain times of the year, based upon past experience, the Department expects that all reasonable steps will be taken to accommodate these fluctuations. Acknowledging non-compliance with the law does not exempt an insurer from potential sanctions. Refer to the answer to question number 26 for a more complete discussion of sanctions for violations of the prompt pay law.

**15. How much information can be shared with the patient by the provider or the insurer when the patient’s employer has not paid the premium? How much information must the insurer share with the provider when the employer has not paid the premium or the payment has not yet been processed?**

G.S. 58-3-225(b) clearly recognizes that insurers may deny or pend claims due to unpaid premiums. The prompt pay law does not prevent providers or insurers from informing insureds (when the insured is not the claimant) of non-payment of premium by an employer group. North Carolina law requires a minimum grace period for payment of premiums. (Ten days for policies with monthly premiums and 31 days for premiums due less frequently.) If a claim is filed for services rendered after premium payment had lapsed, but during the grace period, the insurer may notify the claimant that the claim is pending additional information from the group. If services were rendered during a period that premiums were unpaid, and after the grace period had expired, then the patient was not insured at the time of service and the provider has the right to bill the patient for services. The claim denial notice in such a case must specifically reference the lapse in coverage. *[Refer to G.S. 58-3-225(c)]* North Carolina regulations require insurers’ provider contracts to contain a provision for providers to verify an insured’s eligibility before services are rendered, based upon the latest information available to the insurer. The regulation, 11 NCAC 20.0202(10), also specifies that provider contracts may contain provisions for the treatment of incorrect eligibility information and retroactive terminations due to incorrect or late information given to the insurer by an employer group.

**16. In cases where the insurer suspects a claim is fraudulent, must the notice use the word “fraud” or can other terminology be used to avoid charges of slander?**

Notices to the claimant and to the insured during the period of investigation of a suspected fraudulent claim may be worded in accordance with the advice of the insurer’s legal counsel. *[Refer to G.S. 58-3-225(k)]*

**17. May insurers request missing information directly from an insured when the insured is not the claimant? Must the insurer notify the insured of missing information when the insured is not the claimant?**

The law requires only that the claimant be notified of the need for missing information. If the insurer chooses to request information directly from the insured, the notice to the claimant of the reason the claim cannot be paid must also inform the claimant that the insured has been asked to provide missing information. *[Refer to G.S. 58-3-225(b)]*

**18. What “specific clinical rationale” will be required if the claim is denied?**

If all or part of a claim is denied because of a utilization management or medical necessity standard, the specific clinical rationale for the denial, including reference to the pertinent clinical review criteria that was applied in review of the claim must be provided. “Clinical review criteria” is defined in G.S. 58-50-61(a)(2). The Department expects the notice to contain sufficient pertinent detail to inform the claimant of the insurer’s reasoning, based upon the specific facts of the case. The notice must also include information on how to request the clinical review criteria used in evaluating the claim. If the specific clinical rationale has already been provided in a noncertification notice under G.S. 58-50-61(h), then the insurer is not required to repeat that information in the claim denial notice, but may instead make reference to the previous noncertification notice. In cases where the specific clinical rationale has not been provided previously, the denial notice must include the clinical rationale as described above. *[Refer to G.S. 58-3-225(c)]*

**19. Are insurers required to report interest payments separately on the Remittance Advice and identify the associated claim?**

Although there is no specific requirement as to the reporting of interest payments, insurers must be able to demonstrate their compliance with the statute, including the payment of interest on claims not paid within statutory time frames. In order to demonstrate compliance, it will be necessary for insurers to provide sufficient detail for each claim where interest is owed, including the amount of interest owed and the time period for which it was paid. Thus, the reporting of interest on an individual claim basis should be a byproduct of this requirement, however, there may be more than one way for an insurer to fulfill the requirement.

**20. Is the insurer to pay interest automatically, or is the claimant to request the interest? Can a provider invoice the insurer for the amount of interest owed?**

Insurers are required to automatically pay interest on claims not paid within statutory time frames, without placing the burden of requesting interest payment on the claimant. In order to demonstrate compliance with the law, insurers must maintain individual claim records showing the interest paid for each claim that is subject to an interest payment. Provider invoices cannot be a substitute for an insurer’s automatic calculation and payment of interest, or for an insurer’s record of interest paid on each claim where interest was due. The law does not prevent a mutual agreement between a provider and an insurer for a periodic reconciliation of interest payments made by the insurer, compared to the provider’s own calculation of interest due.

**21. If partial payment is made within the statutory time frames and only part of the claim is paid late, is interest due only on the portion of the claim that is paid late, or on the whole claim?**

Interest is due only on the portion of a claim that is not paid within the time frame established in the law.

**22. In cases where the insurer did not believe that interest was due and did not pay it, but the claimant demonstrates that interest should have been paid, when would interest start/stop accruing?**

Interest would start accruing on the date that payment should have been made (i.e., 30 days after receipt of adequate proof of loss) and would stop accruing on the date the payment was made.

**23. What if the payment amount was less than it should have been? Is interest owed on the**

**amount underpaid?**

Where there is no provider contract or where the subject is not addressed in the provider contract, the insurer is required to pay claims in accordance with the insurance contract. Insurers must make adjusted payments when the initial payment was less than it should have been, with interest due on the amount that was underpaid. Contracts between insurers and providers may specify the conditions and circumstances under which corrections to underpayments are subject to interest. *[Refer to G.S. 58-3-225(h)]*

**24. Must the provider pay interest to the insurer when returning overpayments and if so, when would the interest begin to accrue?**

The prompt pay law does not require providers to pay interest on overpayments being returned to the insurer. Rather, it states that recoveries are to be made pursuant to contracts between insurers and providers and that the contracts may specify whether interest is to be paid on overpayments. However, if the insurer had originally paid interest on the overpayment amount, then the insurer may request a refund of the interest along with the overpayment. When recouping overpayments, insurers must give sufficient detail so that providers can identify the specific claim against which the recoupment is being made. *[Refer to G.S. 58-3-225(h)]*

**25. Is there a time limit for recoupment of overpayments?**

The prompt pay law does not specify a time limit within which insurers can recoup overpayments made to providers but states that the time period for recoveries can be established in the contract between the insurer and the provider. If this is not specifically addressed in the provider contract, then the appropriate statute of limitations would apply. *[Refer to G.S. 58-3-225(h)]*

**26. Is the insurer subject to sanctions for all late payments?**

No. G.S. 58-3-225(j) provides that if the insurer has paid interest “in good faith” along with payment of the claim, no additional sanctions for that late payment are called for in the law. In addition, G.S. 58-3-225(k) provides that insurers are not in violation of the law if their failure to pay a claim is due to “matters beyond the insurer’s reasonable control” or if the insurer has a “reasonable basis to believe” the claim is fraudulent and the claimant is notified accordingly. An insurer is subject to the sanctions in G.S. 58-2-70, if the Department establishes that the insurer has violated the law. Examples of violations of the law would include an established pattern or practice of failure to make required interest payments, or an excessive number of late payments, even where interest is paid, or systematic delays in making payments after claims have been processed and approved for payment. Regardless of whether penalties are likely to apply, insurers are expected to pay claims timely as a general practice and to pay interest promptly on claims paid late. Although providers should not expect the Department to intervene in every dispute over individual claims, the Department will continuously monitor filed complaints, in order to evaluate whether such patterns or practices potentially exist.

**27. When must a claim status report be sent to the insured?**

A claim status report must be sent to the insured if a claim submitted by a provider has not been paid or denied 60 days after the date of initial receipt, unless the insurer is awaiting information it has requested from the provider. A claim status report is not required during the period of time the insurer is awaiting requested information. Upon receipt of the requested information, a claim status report must be sent to the insured indicating that the claim is under review. A copy of this initial report need not be sent to the provider. If the claim remains unresolved 30 days after the first claim status report, another claim status report must be sent to the insured and a copy to the provider. Claim status reports must be sent to the insured and to the provider every 30 days while the claim remains unresolved. In the event additional information has been requested but not received within 90 days of the request, the insurer must deny the claim and provide notice to the claimant. *[Refer to G.S. 58-3-225(d) and (g)]*

**28. Does the 45-day notice of unpaid claims, required under 11 NCAC 4.0319(5), apply to claims subject to the prompt pay law?**

No. The claim status report required at 60 days replaces the 45-day notice requirement. The 45-day notice under 11 NCAC 4.0319 would only be applicable to business exempt from the prompt pay statutes, such as claims under Medicare supplement and long-term care plans.

**29. Are electronic records acceptable? If so, will insurers have to maintain stagnant fields to show interim communications with claimants?**

Insurers may maintain all of their records in electronic format. Records documenting compliance with all aspects of the law are required. This would mean, for example, that a field containing the date a claim was received could not be overwritten by the date additional information was received, unless a record of that date is maintained elsewhere. *[Refer to G.S. 58-3-225(i)]*

**30. Does the exclusion of long-term or nursing home care under G.S. 58-3-225(1)(a) apply to coverage of skilled nursing services when those are included in a benefit plan?**

A stand-alone long-term care insurance carrier is exempt from the definition of benefit plan. Claims for nursing home services within an otherwise eligible plan shall comply with the law.

**31. Is a TPA administering claims for an insured plan subject to the prompt pay law?**

A TPA is not directly subject to the law, however the insurer contracting with the TPA is subject to the law. The insurer employing the services of a TPA must stipulate that the TPA will administer claims according to state insurance laws, and the insurer will remain liable for any failure of the TPA to comply. The responsibilities of the TPA as to any of these matters shall be set forth in the agreement between the TPA and the insurer.

**32. Does the prompt pay law apply when a TPA is administering for a self-funded plan?**

An employee benefit plan established by an employer pursuant to the Employee Retirement Income Security Act (ERISA) of 1974 is not subject to State insurance laws, due to federal preemption. Thus, a self-funded plan is subject to federal regulations under ERISA, with respect to claim payments, and North Carolina's prompt pay law does not apply.

**33. How are providers to know who the insurer is and whether the group is fully or self-insured?**

At the time service is rendered, the provider has an opportunity to collect, update or reconfirm patient information, including a copy of the patient's health insurance card. State law cannot dictate the information to be included on ID cards for self-funded plans. Therefore, insured status may not be clear, especially if the plan is administered by an insurance company or an HMO. However, the plan administrator should confirm self-funded status upon inquiry by the claimant. The Department acknowledges that this situation can pose problems for providers.

**34. Are MEWAs subject to the prompt pay law? MEWAs are not protected by a guaranty association and sanctions might threaten the solvency of their operations.**

North Carolina-licensed MEWAs are subject to the prompt pay law. The prompt pay law does not make any special allowances for North Carolina-licensed MEWAs, with respect to sanctions and/or interest payments related to "prompt pay" violations. The law would not preclude MEWAs from protecting their finances by making their claims administrators contractually responsible for such amounts, in instances of non-compliant claims processing performance.

**35. How will the provisions of the prompt pay law affect plans that are administered by North Carolina insurers, but that are underwritten out of state?**

If the North Carolina insurer is merely administering a health plan underwritten and validly issued out of state by another insurer and is not assuming any risk under that contract, North Carolina insurance laws, including prompt payment law, would not apply to those contracts.

**36. What impact do Federal ERISA Claim Rules have on the provisions of the prompt pay law?**

A brief comparison of provisions for decisions on post-service claims is as follows:

Time within which to file a claim: *Federal Rules* – Rules are silent on how long a claimant has to file a claim from the date of service.

*State Law* – Law permits insurers to limit the time for submission of claims to 180 days, which can be extended in the event of legal incapacity of the insured claimant. Time within which to pay a claim:

*Federal Rules* – Rules require claims to be paid within 30 days of receipt of the claim, which may be extended up to an additional 15 days for matters beyond administrator’s control. For extensions due to failure of the claimant to submit necessary information, the claimant is given 45 days from receipt of the notice to provide the requested information.

*State Law* – Law requires claims to be paid within 30 days of receipt of the claim. If additional information is requested, the claim must be paid 30 days from receipt of the information. If requested information not received within 90 days, the insurer must deny the claim.

Based on conversations with the US Department of Labor (US DOL), it appears that certain provisions of North Carolina’s prompt pay law may conflict with the ERISA Claim Rules regarding the time allowed to process a claim in those cases where additional information is necessary to process the claim. Specifically, allowing up to 30 days to review the initial claim plus up to 30 days more to review the additional information requested may exceed what appears to be a single 30-day period for decision allowed in the federal rule. The Department will proceed with requesting a formal advisory opinion from the US DOL and will issue an update on this matter. In addition, we will consider pursuing appropriate legislation amending our law to conform to the federal rule. Meanwhile, insurers should keep in mind that, regardless of whether North Carolina laws are amended, they will need to comply with the federal rules when they go into effect on January 1, 2002. The Department is still analyzing the federal regulations with respect to North Carolina laws that apply to utilization review, appeals and grievances.

### **37. Will the Department require insurers to report on their claim payments?**

The law does not establish a requirement for regular reporting on claims processed, but the Department may require special reports to evaluate compliance with the law. Although definite plans do not exist at this time, it is very likely that the Department will evaluate compliance with this law some time in 2002. In addition, insurers will be required to make claim payment data available during their market conduct examinations.

### **38. When must insurers that qualify for delayed compliance with the law be in full compliance?**

**\*\*\* SEE UPDATE LISTED IN SECTION II OF THIS DOCUMENT \*\*\***

Insurers that qualify for delayed compliance will be subject to the law when their new claims processing systems are implemented, beginning as claims are entered into the new system. However, whether or not the new system is fully implemented, the company must be in full compliance for all claims received on or after January 1, 2003. Following is an update on the insurers that have asserted eligibility for delayed compliance:

Connecticut General Life Insurance Company (CGLIC)

CGLIC, a CIGNA affiliate, has two claim systems that qualify for delayed compliance. CGLIC’s indemnity, preferred provider and dental claims are currently processed on the CIGNA-Claim adjudication system. Some CGLIC indemnity and preferred provider claims are also processed on the Medicom claims system. The CIGNA-Claims system was implemented in April 1979 and the Medicom System in October 1981. CGLIC plans to migrate all business to a new claims adjudication system with a target date of 1<sup>st</sup> quarter 2002. 35,269 (13%) of CGLIC’s covered lives in North Carolina are supported by one of the old claim systems.

Blue Cross & Blue Shield North Carolina (BCBSNC)

All of BCBSNC products, both group and individual, are currently adjudicated using the “legacy” system, except for BCBSNC’s newest group products: Blue Options (PPO), Blue Choice (POS), Classic Blue (CMM), and Blue Care (HMO). BCBSNC’s “legacy” system, also known as LRHP, was implemented prior to 1982. Group business is being converted to the new products supported by a new claims system as each group renews. Given existing renewal dates, all groups would be converted to a new product and would be in compliance with the prompt pay law, by July 2002. It is possible that some groups will remain on the LRHP system, and changes



will be made to bring that system into compliance with the law not later than December 31, 2002. Individual business will be brought into compliance by December 31, 2001, either by moving that business to the new claims system or by modifying the LRHP system. As of December 31, 2000, 524,075 (96%) of total insured lives were covered under a product supported by the legacy system. Of the 524,075 lives, 345,767 are covered under group and 169,308 are covered under individual policies. Both companies have been asked to provide the Department with quarterly updates on the number of lives and the percentage of business impacted by these older systems and status reports of progress made. Additionally, they have been informed to maintain all records processed on the older systems for future audits by the Department.

**39. Will the Department publish information regarding the effects of the prompt pay law?**

The Department does expect to report on the effects of the law when sufficient experience-based information becomes available. Insurers' compliance with the prompt pay law will be evaluated during market conduct examinations and those findings will be included in final examination reports.

**40. How shall insurers account for the expense of interest payments in rate development and financial reporting?**

Interest expenses are to be classified as administrative and not medical expenses for these purposes.

**41. Do references in the prompt pay law to a number of days, mean calendar days or business days?**

Subsection (b) of G.S. 58-3-225 refers to "business days" for purposes of determining the presumed date of receipt of a claim that has been mailed and "calendar days" for action to be taken by the insurer. Unless otherwise specified in the law, the number of days within which some action must be taken refers to calendar days. If the referenced calendar day falls on a weekend or a holiday, then the first business day following that day will be considered the date the required action must be taken.

**42. Will insurers be required to report interest payments to claimants for tax purposes, and will claimants be required to report interest as income?**

The Department is not qualified to give tax advice, and is not responsible for verifying compliance with tax laws. Insurers should contact the IRS or seek professional advice concerning their obligations to issue 1099INT forms to claimants who were paid interest. Upon inquiry to the NC Department of Revenue, we were advised that interest income generally is reportable, regardless of whether a 1099INT form was issued. However, providers are advised to contact the IRS or seek professional advice regarding their tax obligations for interest income.

**SECTION II. CHANGES & UPDATES TO ITEMS ADDRESSED ON FEBRUARY 21, 2001**

**Regarding:**

**10. Are there cases when a claimant would be permitted to file a claim in more than 180 days (or longer than the contractually allowed time, if that is more than 180 days)?**

G.S. 58-3-225(f) provides that unless otherwise agreed to by the insurer and the claimant, insurers must allow a claim to be submitted up to one year after the required date of submission (i.e., 180 days after the date of SERVICE or discharge plus one year), if it was not reasonably possible for the claim to be submitted within 180 days, and if the claim was submitted as soon as possible thereafter. Force majeure is assumed to be the standard for a provider's reasonable inability to file a claim within the established time frame, though contracts may include provisions establishing more generous standards. When the claimant is the insured, legal incapacity could extend the filing time beyond the one year extension. *[Refer to G.S. 58-3-225(f)]*

**Regarding:**

**38. When must insurers that qualify for delayed compliance with the law be in full compliance?**

Insurers that qualify for delayed compliance will be subject to the law when their new claims processing systems are implemented, beginning as claims are entered into the new system. However, whether or not the new system is fully implemented, the company must be in full compliance for all claims received on or after January 1, 2003. Following is an update on the insurers that have asserted eligibility for delayed compliance:

Connecticut General Life Insurance Company (CGLIC) CGLIC, a CIGNA affiliate, has advised the Department that all of its claims systems will be capable of complying with the Prompt Pay law effective July 1, 2001. Therefore, this company will be subject to the law when it first goes into effect.

Blue Cross & Blue Shield North Carolina (BCBSNC)

All of BCBSNC products, both group and individual, are currently adjudicated using the "legacy" system, except for BCBSNC's newest group products: Blue Options (PPO), Blue Choice (POS), Classic Blue (CMM), and Blue Care (HMO). BCBSNC's "legacy" system, also known as LRHP, was implemented prior to 1982. Group business is being converted to the new products supported by a new claims system as each group renews. Given existing renewal dates, all groups would be converted to a new product and would be in compliance with the prompt pay law, by July 2002. It is possible that some groups will remain on the LRHP system, and changes will be made to bring that system into compliance with the law not later than December 31, 2002. Individual business will be brought into compliance by December 31, 2001, either by moving that business to the new claims system or by modifying the LRHP system. As of December 31, 2000, 524,075 (96%) of total insured lives were covered under a product supported by the legacy system. Of the 524,075 lives, 345,767 are covered under group and 169,308 are covered under individual policies. WellPath Select, Inc.: All of WellPath Select's policies (110,760 as of February 2001) are supported by the GEMS system, which came into use at WellPath via a chain of mergers and acquisitions. The company is working to transfer this business to another system by January, 2002.

### **SECTION III. ADDITIONAL QUESTIONS AS OF APRIL 27, 2001**

#### **1. Does the Prompt Pay law apply to claims from out of state providers?**

The law applies to the claims payment practices of North Carolina-licensed insurers, without regard to the residence of the provider filing the claim. A claim filed on behalf of a person insured by a North Carolina insurer must be processed in accordance with North Carolina law.

#### **2. If a claim status report is not required to be sent on day 60 because the insurer was awaiting information requested from the provider, how soon must the claim status report be sent to the insured once the information is received?**

Under 58-3-225(g), a status report is to be provided to the insured in the following circumstance: (1) A claim is unpaid after 60 days, and (2) the insurer is no longer awaiting requested information. Subsequent status reports are then to follow every 30 days thereafter. Since the law does not specify a time frame for sending the status report after requested information has been received (#2, above), the Department believes it is necessary, for administrative and regulatory purposes, to establish a reasonable compliance standard. The Department will consider companies to be in compliance with this provision if the claim status report is mailed to the insured within 5 business days of receipt of the additional information. If the claim is paid or denied within the 5 business days of receipt of the additional information, then no claim status report is required.

#### **3. How does the 180-day limit for claims filing apply when the insurer is a secondary payor?**

The prompt pay law requires that insurers allow at least 180 days from the date of service or discharge for a claim to be filed, but they may allow more time than that. No distinction is made in the law for primary or secondary coverage. The processing requirements and time frames would apply beginning with the date the claim is filed, whether the claim is for primary or secondary coverage. Nothing prohibits an insurer from establishing a COB policy that allows a longer filing period when the insurer is secondary. For example, an insurer may require a provider to file a claim within a specified number of days after payment is received from the primary insurer.

Indication of a fair business practice would be equitable treatment of all COB claims, in accordance with state law and the insurer's own established policies.

**4. If a claim is denied due to missing information, may the claimant later re-submit the claim including the information that was missing when the first claim was filed? If so, what time limit applies for re-submitting the claim?**

Insurers should be sure that a denial due to missing information is done in good faith. The denial notice issued must include all of the reasons for denial, including the fact that information is missing and what that information is. A claimant may choose to resubmit the claim including the information that had previously been identified as missing. This resubmission would be treated as a new claim filing subject to the Prompt Pay law and the insurer's policy or provider contract terms for submitting claims. By law, the policy and contract must allow at least 180 days from the date of service or, for inpatient services, date of discharge. An insurer cannot deny a claimant the right to re-file a claim that was denied due to missing information, when the claimant is able to provide the missing information with the resubmission. An insurer may establish, communicate, and enforce procedures that require resubmissions to indicate that additional or corrected information is included with the resubmission so as to enable the insurer to distinguish resubmissions from duplicate filings.

**5. How does the prompt pay law impact interim billing by a provider? Can the claim be pended as an "incomplete claim" or "unclean claim"?**

An insurer must pay any portion of a claim for which proof of loss can reasonably be established. If no part of the claim is payable, then the insurer can either deny the claim, itemizing all of the "good faith" reasons for the denial, or it can pend the claim and itemize all of the missing information required. Either way, the claim must be handled in accordance with applicable time standards.

**6. If a claim cannot be processed because of missing information, can the insurer deny the claim and request information, instead of pending the claim? If the insurer denies the claim, must they deny it again after 90 days if the missing information is not submitted?**

See answer in number 4 and 5, above. The insurer must either pay, deny or pend a claim or portion of a claim. If information is missing, the insurer can either deny or pend the claim. If the claim is denied, they must provide all of the reasons for the denial. Even if some of the reasons for denial relate to missing information, the claim is still denied and not pended.

**7. When a claim that is submitted by a provider is denied, must the insurer send a denial notice to the insured?**

In cases where the provider is not permitted to bill the patient in the event of claim denial, no notice must be given to the insured. If the insured remains liable for payment to the provider in the event of claim denial, the notice of denied claim must go to the insured as well as the provider, since they would both qualify as claimants.

**8. If an insurer receives a claim and requests information, then receives another claim for which they need the same information that has already been requested, do they have to request the information again?**

Every claim must be handled in accordance with the law. The insurer may either deny the second claim, itemizing all of the good faith reasons for the denial, or pend it and specify the missing information. An earlier request for the same information relating to another claim does not remove the requirement to process later claims in accordance with the law. However, once the information is received in response to either request, processing should continue for both claims.

**9. There should be guidelines for sufficient evidence to rebut the presumed date of receipt of payment, similar to the evidence for rebuttal of the presumed date of receipt of a claim, as outlined in the Department's guidance issued February 21, 2001(Question #3).**

The law establishes a presumed date that payment is made [G.S. 58-3-225(e)], but not a presumed date payment is received. The Department will apply a standard of proof similar to that

outlined in the above-referenced guideline, to assertions by providers that payment was not made on the presumed date.

**10. Are dental plans subject to Prompt Pay?**

Yes. The definition of “health benefit plan” in 58-3-225 does not specifically exclude dental plans, so they are included among insurers subject to the law.

**11. In a case where the insured fails to provide COB information to the insurer or provider when asked for that information, and the insurer denies a claim submitted by a provider because COB information is missing, may the provider ever balance-bill the insured?**

In a case where a claim denial is solely the result of a member’s failure to provide COB information, any member hold-harmless provision or restriction on balance billing would not apply since the member would not have fulfilled their obligations with respect to the health benefit policy or assignment of benefits.

**12. The insurers who have so far qualified for a delayed effective date for compliance have some of their membership on a “new” claims system that is subject to the law on July 1, 2001, and some on an “old” system that qualifies for the extension. How can providers confirm when a claim submitted to one of these insurers is on the “old” system?**

The Department will post quarterly information about the number of insureds and, if applicable, the product names supported by these companies’ “old” claim system. The information will be posted on the Department’s web site, [www.NCDOI.com](http://www.NCDOI.com), under the section with information for providers. However, this information will be of limited usefulness. Providers will need to rely on insurers to provide information relative to a specific patient and whether a claim for services provided to them is subject to the Prompt Pay law.

## **Attachment B: Prompt Pay Statute-Recoupment Limitation**

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

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments may be made not more than two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may not exceed two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor. (2000-162, s. 4(a); 2001-417, s. 1; 2007-362, s. 1.)

## **Attachment C-1: Credentialing Statute**

### **§ 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 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.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167. (2001-172, s. 1; 2002-126, s. 6.9(a); 2005-223, s. 9.)

## Attachment C-2: Credentialing Regulations

### SECTION .0400 - NETWORK PROVIDER CREDENTIALS

#### 11 NCAC 20 .0401 CREDENTIAL VERIFICATION PROGRAM

In order to assure accessibility and availability of services, each carrier shall establish a program in accordance with this Section that verifies that its network providers are credentialed before the carrier lists those providers in the carrier's provider directory, handbooks, or other marketing or member materials.

*History Note:* Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996.

#### 11 NCAC 20 .0402 ORGANIZATION STRUCTURE

The program established under Rule .0401 of this Section shall provide for an identifiable person or persons to be responsible for all credential verification activities, which person or persons shall be capable of carrying out that responsibility.

*History Note:* Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996.

#### 11 NCAC 20 .0403 WRITTEN CREDENTIAL VERIFICATION PLAN

Each carrier shall develop and adopt a written credentialing plan that contains policies and procedures to support the credential verification program. The plan shall include:

- (1) The purpose, goals, and objectives of the credential verification program.
- (2) The roles of those persons responsible for the credential verification program.

*History Note:* Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996.

#### 11 NCAC 20 .0404 APPLICATION

For all providers who submit applications to be added to a carrier's network on or after October 1, 2001:

- (1) Each carrier shall obtain and retain on file a complete signed and dated application on the form approved by the Commissioner under G.S. 58-3-230. All required information shall be current upon final approval by the carrier. The application shall include, when applicable:
  - (a) The provider's name, address, and telephone number.
  - (b) Practice information, including call coverage.
  - (c) Education, training and work history.
  - (d) The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.
  - (e) Drug Enforcement Agency (DEA) registration number and prescribing restrictions.
  - (f) Specialty board or other certification.
  - (g) Professional and hospital affiliation.
  - (h) The amount of professional liability coverage and any malpractice history.
  - (i) Any disciplinary actions by medical organizations and regulatory agencies.
  - (j) Any felony or misdemeanor convictions.
  - (k) The type of affiliation requested (for example, primary care, consulting specialists, ambulatory care, etc.).
- (l) A statement of completeness, veracity, and release of information, signed and dated by the applicant.
- (m) Letters of reference or recommendation or letters of oversight from supervisors, or both.

- (2) The carrier shall obtain and retain on file the following information regarding facility provider credentials, when applicable:
  - (a) Joint Commission on Accreditation of Healthcare Organization's certification or certification from other accrediting agencies.
  - (b) State licensure.
  - (c) Medicare and Medicaid certification.
  - (d) Evidence of current malpractice insurance.
- (3) No credential item listed in Items (1) or (2) of this Rule shall be construed as a substantive threshold or criterion or as a standard for credentials that must be held by any provider in order to be a network provider.

*History Note:* Authority G.S. 58-2-40(1); 58-2-131; 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996; Temporary Amendment Eff. October 1, 2001; Amended Eff. August 1, 2002.

### **11 NCAC 20 .0405 VERIFICATION OF CREDENTIALS**

(a) Each carrier's process for verifying credentials shall take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall make allowance for the scheduling of a final decision by a credentialing committee, if the carrier's credentialing program requires such review.

(b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60<sup>th</sup> day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant.

(c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures:

- (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant.
- (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule.
- (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

(d) If a carrier elects not to include an applicant in its network, for reasons that do not require review of the application, the carrier shall provide written notice to the applicant of that determination within 30 days after receipt of the application.

(e) Nothing in this rule shall require a carrier to include a health care provider in its network or prevent a carrier from conducting a complete review and verification of an applicant's credentials, including an assessment of the applicant's office, before agreeing to include the applicant in its network.



*History Note:* Authority G.S. 58-2-40(1); 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996; Temporary Amendment Eff. October 1, 2001; Eff. July 1, 2002.

#### **11 NCAC 20 .0406 PROVIDER FILES**

Each carrier shall maintain centralized files, either paper or electronic, on each individual provider making application to affiliate with the carrier. Each file shall include documentation of compliance with Rules .0404 and .0405 of this Section.

*History Note:* Authority G.S. 58-2-40(1); 58-2-131; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996.

#### **11 NCAC 20 .0407 REVERIFICATION OF PROVIDER CREDENTIALS**

Each carrier shall reverify the credentials of all network providers at least every three years. On or after October 1, 2001, carriers shall use the form approved by the Commissioner under G.S. 58-3-230. Carriers may require completion of all or only selected sections of the form for reverification of credentials.

*History Note:* Authority G.S. 58-2-40(1); 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996; Temporary Amendment Eff. October 1, 2001; Amended Eff. August 1, 2002.

#### **NCAC 20.0408 CONFIDENTIALITY**

Each carrier shall develop written policies and procedures to protect the confidentiality of patient health or medical record information and personal information, as provided by law.

*History Note:* Authority G.S. 58-2-40(1); 58-2-131; 58-39-45; 58-39-75; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-180; Eff. October 1, 1996.

#### **11 NCAC 20 .0409 RECORDS AND EXAMINATIONS**

Each carrier shall maintain all records related to credential verification in a manner that the carrier deems to be adequate for a period of three years or until the completion of the triennial examination conducted by the Department, whichever is later.

*History Note:* Authority G.S. 58-2-40(1); 58-2-131; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996.

#### **11 NCAC 20 .0410 DELEGATION OF CREDENTIAL VERIFICATION ACTIVITIES**

Whenever any carrier delegates credential verification activities to a contracting entity, whether an intermediary or subcontractor, the carrier shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements in this Section. The carrier shall monitor the contracting entity's credential verification activities. The carrier shall implement oversight mechanisms, including:

- (1) Reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures.
- (2) Requiring the contract entity to submit an updated list of providers no less frequently than quarterly.
- (3) Conducting an evaluation of the contracting entity's credential verification program at least every three years.

*History Note:* Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996.

**11 NCAC 20 .0411 SUSPENSION OR TERMINATION OF NETWORK PROVIDERS**

Each carrier shall have a mechanism in place to reduce, suspend, or terminate the participation of any network provider.

*History Note:* Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996.

## Attachment D: North Carolina Disclosure Statute

### § 58-3-227. Health plans fee schedules.

- (a) Definitions. – As used in this section, the following terms mean:
- (1) Claim submission policy. – The procedure adopted by an insurer and used by a provider or facility to submit to the insurer claims for services rendered and to seek reimbursement for those services.
  - (2) Health care facility or facility. – A facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
  - (3) Health care provider or provider. – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.
  - (4) Insurer. – An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter, except it does not include an entity that writes stand alone dental insurance.
  - (5) Reimbursement policy. – Information relating to payment of providers and facilities including policies on the following:
    - a. Claims bundling and other claims editing processes.
    - b. Recognition or nonrecognition of CPT code modifiers.
    - c. Downcoding of services or procedures.
    - d. The definition of global surgery periods.
    - e. Multiple surgical procedures.
    - f. Payment based on the relationship of procedure code to diagnosis code.
  - (6) Schedule of fees. – CPT, HCPCS, ICD-9- CM codes, ASA codes, modifiers, and other applicable codes for the procedures billed for that class of provider.

(b) Purpose. – The purpose of this section is to establish the minimum required provisions for the disclosure and notification of an insurer's schedule of fees, claims submission, and reimbursement policies to health care providers and health care facilities. Nothing in this section shall supersede (i) the schedule of fees, claim submission, and reimbursement policy terms in an insurer's contract

with a provider or facility that exceed the minimum requirements of this section nor (ii) any contractual requirement for mutual written consent of changes to reimbursement policies, claims submission policies, or fees. Nothing in this section shall prevent an insurer from requiring that providers and facilities keep confidential, and not disclose to third parties, the information that an insurer must provide under this section.

(c) **(See Editor's note)** Disclosure of Fee Schedules. – An insurer shall make available to contracted providers the following information:

- (1) The insurer's schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider, and, upon request, the full schedule of fees for services or procedures billed by that class of provider, in accordance with subdivision (3) of this subsection.
- (2) In the case of a contract incorporating multiple classes of providers, the insurer's schedule of fees associated with the top 30 services or procedures most commonly billed for each class of provider, and, upon request, the full schedule of fees for services or procedures billed for each class of provider, in accordance with subdivision (3) of this subsection.
- (3) If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider. The insurer may also limit the frequency of requests for the additional codes by each provider, provided that such additional codes will be made available upon request at least annually and at any time there are changes for which notification is required pursuant to subsection (f) of this section.

(d) Disclosure of Policies. – An insurer shall make available to contracted providers and facilities a description of the insurer's claim submission and reimbursement policies.

(e) Availability of Information. – Insurers shall notify contracted providers and facilities in writing of the availability of information required or authorized to be provided under this section. An insurer may satisfy this requirement by indicating in the contract with the provider the availability of this information or by providing notice in a manner authorized under subsection (f) of this section for notification of changes.

(f) Notification of Changes. – Insurers shall provide advance notice to providers and facilities of changes to the information that insurers are required to provide under this section. The notice period for a change in the schedule of fees,

reimbursement policies, or submission of claims policies shall be the contractual notice period, but in no event shall the notices be given less than 30 days prior to the change. An insurer is not required to provide advance notice of changes to the information required under this section if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case, notification of the changes may be made concurrent with the implementation of the changes. Information and notice of changes may be provided in the medium selected by the insurer, including an electronic medium. However, the insurer must inform the affected contracted provider or facility of the notification method to be used by the insurer and, if the insurer uses an electronic medium to provide notice of changes required under this section, the insurer shall provide clear instructions regarding how the provider or facility may access the information contained in the notice.

(g) Reference Information. – If an insurer references source information that is the basis for a schedule of fees, reimbursement policy, or claim submission policy, and the source information is developed independently of the insurer, the insurer may satisfy the requirements of this section by providing clear instructions regarding how the provider or facility may readily access the source information or by providing for actual access if agreed to in the contract between the insurer and the provider.

(h) Contract Negotiations. – When an insurer offers a contract to a provider, the insurer shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of a provider, the insurer shall also make available the full schedule of fees for services or procedures billed by that class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider.

(i) **(See Editor's note)** Exemptions. – Except for the information required to be provided under subsection (c) of this section, this section does not apply to:

- (1) Claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer (i) verifies with the Commissioner that its claims adjudication system qualified under this subsection, (ii) is implementing a new claims adjudication software system, and (iii) is proceeding in good faith to move all insured claims to the new system as soon as possible and in any event no later than December 31, 2004; or
- (2) Information that the insurer verifies with the Commissioner is required to be provided by the terms of a national settlement

agreement between the insurer and trade associations representing certain providers, provided that the agreement is approved prior to March 1, 2004, by the court having jurisdiction over the settlement. The exemption provided in this subdivision shall be limited to those terms of the agreement that are required to be implemented no later than December 31, 2004. Nothing in this subdivision shall be construed to relieve the insurer of complying with any terms and deadlines as set out in the agreement. (2003-369, s. 1.)

## **Attachment E: North Carolina Patient Bill of Rights**

*NCGS §58-67-88: Continuity of Care; NCGS §58-3-223: Managed Care Access to Specialist Care; NCGS §58-3-235: Selection of Specialist as Primary Care Provider; NCGS §58-3-240: Direct Access to Pediatrician for Minors; NCGS §58-3-221: Access to Non-Formulary and Restricted Access Prescription Drugs; NCGS §143-730: Managed Care Patient Assistance Program; NCGS §58-50-30: Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant; NCGS §58-3-191: Managed Care Reporting and Disclosure Requirements; NCGS §58-3-245: Provider Directories; NCGS §58-3-250: Payment Obligation for Covered Services; NCGS §58-3-255: Coverage of Clinical Trials; NCGS §58-3-265: Prohibition on Managed Care Provider Incentives; Independent External Review (NCGS §58-50-75, §58-50-77, §58-50-79, §58-50-80, §58-50-82, §58-50-84, §58-50-85, §58-50-87, §58-50-89, §58-50-90, §58-50-92, §58-50-93, §58-50-94, §58-50-95); Managed Care Entity Liability (NCGS §90-21-50, §90-21-51, §90-21-52, §90-21-53, §90-21-54, §90-21-55, §90-21-56)*

### **§ 58-67-88. Continuity of care.**

- (a) Definitions. – As used in this section:
  - (1) "Ongoing special condition" means:
    - a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
    - b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
    - c. In the case of pregnancy, pregnancy from the start of the second trimester.
    - d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.
  - (2) "Terminated or termination". – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

- (1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section if the individual has filed a claim with the HMO for services provided by the terminated provider or the individual is otherwise known by the HMO to be a patient of the provider.
- (2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

- (1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.
- (2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation,



or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through post-discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

- (1) When care is provided pursuant to subdivision (b)(2) of this section, the provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full. When care is provided pursuant to subdivision (c)(2) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the HMO and the insured for all covered services.
- (2) The provider agrees to comply with the quality assurance programs of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided. The quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the patient.
- (3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers,

including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

- (4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.
  - (5) The provider agrees to discontinue providing services at the end of the transition period pursuant to this section and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.
- (i) Construction. – Nothing in this section:
- (1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, requires the coverage of benefits not provided under the new policy under which the person is covered.
  - (2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.
  - (3) Prohibits an HMO from extending any transitional period beyond that specified in this section.
  - (4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.
- (j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description. (2001-446, s. 1.)

**§ 58-3-223. Managed care access to specialist care.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The insurer shall provide for an extended or standing referral to

a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

- (1) "Health benefit plan" has the meaning applied in G.S. 58-3-167.
- (2) "Insurer" has the meaning applied in G.S. 58-3-167.
- (3) "Serious or chronic degenerative, disabling, or life-threatening disease or condition" means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.
- (4) "Specialist" includes a subspecialist. (1999-168, s. 1; 2001-446, s. 1.2.)

**§ 58-3-235. Selection of specialist as primary care provider.**

(a) Each insurer that offers a health benefit plan shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers. (2001-446, s. 1.3.)

**§ 58-3-240. Direct access to pediatrician for minors.**

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children under the age of 18 and covered under the policy. (2001-446, s. 1.4.)

**§ 58-3-221. Access to nonformulary and restricted access prescription drugs.**

(a) If an insurer maintains one or more closed formularies for or restricts access to covered prescription drugs or devices, then the insurer shall do all of the following:

- (1) Develop the formulary or formularies and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee, which shall include participating physicians who are licensed to practice medicine in this State.
- (2) Make available to participating providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices.
- (3) Establish and maintain an expeditious process or procedure that allows an enrollee or the enrollee's physician acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer, after the enrollee's participating physician notifies the insurer that:
  - a. Either (i) the formulary alternatives have been ineffective in the treatment of the enrollee's disease or condition, or (ii) the formulary alternatives cause or are reasonably expected by the physician to cause a harmful or adverse clinical reaction in the enrollee; and
  - b. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.
- (4) Provide coverage for a restricted access drug or device to an enrollee without requiring prior approval or use of a nonrestricted formulary drug if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing

physician, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(c) As used in this section:

(1) "Closed formulary" means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

(1a) "Health benefit plan" has definition provided in G.S. 58-3-167.

(2) "Insurer" has the meaning provided in G.S. 58-3-167.

(3) "Restricted access drug or device" means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer. (1999-178, s. 1; 1999-294, s. 14(a), (b); 2001-446, s. 1.5.)

### **§ 143-730. Managed Care Patient Assistance Program.**

(a) The Office of Managed Care Patient Assistance Program is established in an existing State agency or department designated by the Governor. The Director of the Office of Managed Care Patient Assistance Program shall be appointed by the Governor.

(b) The Managed Care Patient Assistance Program shall provide information and assistance to individuals enrolled in managed care plans. The Managed Care Patient Assistance Program shall have expertise and experience in both health care and advocacy and will assume the specific duties and responsibilities set forth in subsection (c) of this section.

(c) The duties and responsibilities of the Managed Care Patient Assistance Program are as follows:

(1) Develop and distribute educational and informational materials for consumers, explaining their rights and responsibilities as managed care plan enrollees.

(2) Answer inquiries posed by consumers and refer inquiries of a regulatory nature to staff within the Department of Insurance.

(3) Advise managed care plan enrollees about the utilization review process.

- (4) Assist enrollees with the grievance, appeal, and external review procedures established by Article 50 of Chapter 58 of the General Statutes.
- (5) Publicize the Office of the Managed Care Patient Assistance Program.
- (6) Compile data on the activities of the Office and evaluate such data to make recommendations as to the needed activities of the Office.

(d) The Director of the Managed Care Patient Assistance Program shall annually report the activities of the Managed Care Patient Assistance Program, including the types of appeals, grievances, and complaints received and the outcome of these cases. The report shall be submitted to the General Assembly, upon its convening or reconvening, and shall make recommendations as to efforts that could be implemented to assist managed care consumers.

(e) All health information in the possession of the Managed Care Patient Assistance Program is confidential and is not a public record pursuant to G.S. 132-1 or any other applicable statute.

For purposes of this section, "health information" means any of the following:

- (1) Information relating to the past, present, or future physical or mental health or condition of an individual.
- (2) Information relating to the provision of health care to an individual.
- (3) Information relating to the past, present, or future payment for the provision of health care to an individual.
- (4) Information, in any form, that identifies or may be used to identify an individual, that is created by, provided by, or received from any of the following:
  - a. An individual or an individual's spouse, parent, legal guardian, or designated representative.
  - b. A health care provider, health plan, employer, health care clearinghouse, or an entity doing business with these entities. (2001-446, s. 1.6; 2002-159, s. 45.)

**§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.**

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service

corporation, or insurer governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

- (1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and
- (2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a

provider of the services within the network, subject to the requirements of the plan or policy.

(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a "duly licensed psychologist" is a:

- (1) Licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board; or
- (2) Licensed psychological associate who holds permanent licensure.

(c) For the purposes of this section, a "duly licensed clinical social worker" is a "licensed clinical social worker " as defined in G.S. 90B-3(2) and licensed by the North Carolina Social Work Certification and Licensure Board pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(c2) For purposes of this section, a "duly certified substance abuse professional" is a person certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.

(c3) For purposes of this section, a "duly licensed professional counselor" is a person licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.

(c4) For purposes of this section, a "duly licensed marriage and family therapist" is a person licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

- (1) The service performed is within the nurse's lawful scope of practice;
- (2) The policy currently provides benefits for identical services performed by other licensed health care providers;
- (3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;



- (4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
- (5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision, unless these plan requirements apply to all providers for that service.

For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

- (1) The service performed is within the lawful scope of practice of the pharmacist;
- (2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
- (3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

- (1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;
- (2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (a1) of this section, acting within the scope of the

provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection (a1) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (a1) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected.

(h) Nothing in this section shall be construed as expanding the scope of practice of any duly licensed physician or provider listed in subsection (a1) of this section. (1913, c. 91, s. 11; C.S., s. 6488; 1965, c. 396, s. 2; c. 1169, s. 2; 1967, c. 690, s. 2; 1969, c. 679; 1973, c. 610; 1977, c. 601, ss. 2, 31/2; 1991, c. 720, s. 29; 1993, c. 347, s. 2; c. 375, s. 3; c. 464, s. 2; c. 554, s. 1; 1995, c. 193, s. 41, c. 223, s. 1; c. 406, s. 3; 1997-197, ss. 1, 2; 1999-186, s. 1; 1999-199, s. 1; 1999-210, s. 2; 2001-297, s. 1; 2001-446, s. 1.7; 2001-487, s. 40(g); 2003-117, s. 1; 2003-368, s. 1; 2005-276, s. 6.29; 2005-345, ss. 3(a), 3(b); 2007-24, s. 1.)

**§ 58-3-191. Managed care reporting and disclosure requirements.**

(a) Each health benefit plan shall annually, on or before the first day of March of each year, file in the office of the Commissioner the following information for the previous calendar year:

- (1) The number of and reasons for grievances received from plan participants regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every health benefit plan shall file with the Commissioner, as part of its annual grievance report, a certificate of compliance

stating that the carrier has established and follows, for each of its lines of business, grievance procedures that comply with G.S. 58-50-62.

- (2) The number of participants and groups who terminated coverage under the plan for any reason. The report shall include the number of participants who terminated coverage because the group contract under which they were covered was terminated, the number of participants who terminated coverage for reasons other than the termination of the group under which they were enrolled, and the number of group contracts terminated.
- (3) The number of provider contracts that were terminated and the reasons for termination. This information shall include the number of providers leaving the plan and the number of new providers. The report shall show voluntary and involuntary terminations separately.
- (4) Data relating to the utilization, quality, availability, and accessibility of services. The report shall include the following:
  - a. Information on the health benefit plan's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the plan's methodology for:
    1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.
    2. Determining when changes in plan membership will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the health benefit plan's provider network; and an evaluation of actual plan performance against performance targets.

- b. The health benefit plan's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.
- c. Information on the health benefit plan's program to determine the level of provider network accessibility necessary to serve its membership. This information shall include the health benefit plan's methodology for

establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

- d. A statement of the health benefit plan's methods and standards for determining whether in-network services are reasonably available and accessible to a covered person, for the purpose of determining whether a covered person should receive the in-network level of coverage for services received from a nonnetwork provider.
  - e. A description of the health benefit plan's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, plan performance, and network provider performance.
  - f. A summary of the health benefit plan's utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 58-50-61.
- (5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or

incentive payments. This information shall be submitted on a form prescribed by the Commissioner.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

- (1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-126, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;
- (2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;
- (3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;
- (4) The plan's formularies, restricted access drugs or devices as defined in G.S. 58-3-221, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and
- (5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental.

(b1) Effective March 1, 1998, insurers shall make the reports that are required under subsection (a) of this section and that have been filed with the Commissioner available on their business premises and shall provide any insured access to them upon request.

(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans as defined in G.S. 58-50-56. (1997-480, s. 1; 1997-519, s. 1.1; 2001-334, s. 2.2; 2001-446, s. 2.1; 2006-154, s. 13.)

### **§ 58-3-245. Provider directories.**

(a) Every health benefit plan utilizing a provider network shall maintain a provider directory that includes a listing of network providers available to insureds

and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory listing may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each directory listing shall include the following network information:

- (1) The provider's name, address, telephone number, and, if applicable, area of specialty.
- (2) Whether the provider may be selected as a primary care provider.
- (3) To the extent known to the health benefit plan, an indication of whether the provider:
  - a. Is or is not currently accepting new patients.
  - b. Has any other restrictions that would limit an insured's access to that provider.

(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under G.S. 58-3-230. (2001-446, s. 2.2.)

**§ 58-3-250. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

- (1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.
- (2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.

(3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: "NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations." (2001-446, s. 2.3.)

**§ 58-3-255. Coverage of clinical trials.**

(a) As used in this section:

(1) "Covered clinical trials" means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

- a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
- b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
- c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) "Health benefit plan" is defined by G.S. 58-3-167.

(3) "Insurer" is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase II, phase III, and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials. Nothing in this section shall be construed to require a health benefit plan to pay or reimburse for non-FDA approved drugs provided or made available to a patient who received the drug during a covered clinical trial after the clinical trial has been discontinued.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim. (2001-446, s. 3.1.)

**§ 58-3-265. Prohibition on managed care provider incentives.**

An insurer offering a health benefit plan may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to a specific insured or enrollee. This section does not prohibit insurers from paying a provider on a capitated basis or withholding payment or paying a bonus based on the aggregate services rendered by the provider or the insurer's financial performance. (2001-446, s. 1.8.)

**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) **(Effective until July 1, 2008)** This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the Teachers' and State Employees' Comprehensive Major Medical Plan, any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes, 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.

(b) **(Effective July 1, 2008)** This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the State Health Plan for Teachers and State Employees, any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes, 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, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.
- (2) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.
- (3) "Independent review organization" or "organization" means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions. (2001-446, s. 4.5; 2007-298, s. 8.5; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

**Note: For complete review of External Review Statute**

***See also § 58-50-77. Notice of right to external review; §58-50-79, §58-50-80, §58-50-82, §58-50-84, §58-50-85, §58-50-87, §58-50-89, §58-50-90, §58-50-92, §58-50-93, §58-50-94, §58-50-95***

**Managed Care Liability**

**§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.**

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care decisions and is liable for

damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by decisions regarding whether or when the insured or enrollee would receive a health care service made by:

- (1) Its agents or employees; or
- (2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably affect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

- (1) The managed care entity and its agents or employees, or representatives for whom the managed care entity is liable under subsection (b) of this section, did not control or influence or advocate for the decision regarding whether or when the insured or enrollee would receive a health care service; or
- (2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity shall not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed

care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction. (2001-446, s. 4.7.)

**Note: For complete review of Managed Care Liability Statute**

**See also: §90-21-50, §90-21-52, §90-21-53, §90-21-54, §90-21-55, §90-21-56**

## **Attachment F: Prudent Layperson Statute**

### **§ 58-3-190. Coverage required for emergency care.**

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

- (1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or
- (2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

- (1) Coverage of emergency medical services.
- (2) The appropriate use of emergency services, including the use of the "911" system and other telephone access systems utilized to access prehospital emergency services.
- (3) Any cost-sharing provisions for emergency medical services.
- (4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of

other in-plan settings at which covered persons may receive medical care.

- (g) As used in this section, the term:
- (1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
    - a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
    - b. Serious impairment to bodily functions.
    - c. Serious dysfunction of any bodily organ or part.
  - (2) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
  - (3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
    - a. Accident.
    - b. Credit.
    - c. Disability income.
    - d. Long-term or nursing home care.
    - e. Medicare supplement.
    - f. Specified disease.
    - g. Dental or vision.
    - h. Coverage issued as a supplement to liability insurance.
    - i. Workers' compensation.
    - j. Medical payments under automobile or homeowners insurance.
    - k. Hospital income or indemnity.
    - l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be

contained in any liability policy or equivalent self-insurance.

- (4) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.
- (5) "To stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred. (1997-443, s. 11A.122; 1997-474, s. 2.)

## **Attachment G-1: North Carolina Definition of Medical Necessity and Coverage/Network Provisions**

### **§ 58-3-200. Miscellaneous insurance and managed care coverage and network provisions.**

(a) Definitions. – As used in this section:

(1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Accident.
- b. Credit.
- c. Disability income.
- d. Long-term or nursing home care.
- e. Medicare supplement.
- f. Specified disease.
- g. Dental or vision.
- h. Coverage issued as a supplement to liability insurance.
- i. Workers' compensation.
- j. Medical payments under automobile or homeowners insurance.
- k. Hospital income or indemnity.
- l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

- (1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- (3) Within generally accepted standards of medical care in the community.
- (4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

(d) Services Outside Provider Networks. – No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

(e) Nondiscrimination Against High-Risk Populations. – No insurer shall establish provider selection or contract renewal standards or procedures that are designed to avoid or otherwise have the effect of avoiding enrolling high-risk populations by excluding providers because they are located in geographic areas that contain high-risk populations or because they treat or specialize in treating populations that present a risk of higher-than-average claims or health care services utilization. This subsection does not prohibit an insurer from declining to select a provider or from not renewing a contract with a provider who fails to meet the insurer's selection criteria.



(f) Continuing Care Retirement Community Residents. – As used in this subsection, "Medicare benefits" means medical and health products, benefits, and services used in accordance with Title XVIII of the Social Security Act. If an insured with coverage for Medicare benefits or similar benefits under a plan for retired federal government employees is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, and the insured's primary care physician determines that it is medically necessary for the insured to be referred to a skilled nursing facility upon discharge from an acute care facility, the insurer shall not require that the insured relocate to a skilled nursing facility outside the continuing care retirement community if the continuing care retirement community:

- (1) Is a Medicare-certified skilled nursing facility.
- (2) Agrees to be reimbursed at the insurer's contract rate negotiated with similar providers for the same services and supplies.
- (3) Agrees not to bill the insured for fees over and above the insurer's contract rate.
- (4) Meets all guidelines established by the insurer related to quality of care, including:
  - a. Quality assurance programs that promote continuous quality improvement.
  - b. Standards for performance measurement for measuring and reporting the quality of health care services provided to insureds.
  - c. Utilization review, including compliance with utilization management procedures.
  - d. Confidentiality of medical information.
  - e. Insured grievances and appeals from adverse treatment decisions.
  - f. Nondiscrimination.
- (5) Agrees to comply with the insurer's procedures for referral authorization, risk assumption, use of insurer services, and other criteria applicable to providers under contract for the same services and supplies.

A continuing care retirement community that satisfies subdivisions (1) through (5) of this subsection shall not be obligated to accept, as a skilled nursing facility, any patient other than a resident of the continuing care retirement community, and neither the insurer nor the retirement community shall be allowed to list or otherwise advertise the skilled nursing facility as a participating network provider for Medicare benefits for anyone other than residents of the continuing care retirement community. (1997-443, s. 11A.122; 1997-519, s. 2.1; 2001-446, ss. 5(b), 1.2A.)

**Attachment H: North Carolina Department of  
Insurance Bulletin No. 02-B-6: APPLICABILITY OF  
NORTH CAROLINA GENERAL STATUTE § 58-3-200 (d)  
IN THE ENFORCEMENT OF ANTI-ASSIGNMENT  
CLAUSES IN INSURANCE CONTRACTS**

**Bulletin**

**Number 02-B-6**

**TO: Health Maintenance Organizations and Insurers Offering Preferred  
Provider Benefit Plans**

**DATE: June 20, 2002**

**RE: APPLICABILITY OF NORTH CAROLINA GENERAL STATUTE §  
58-3-200 (d) IN THE ENFORCEMENT OF ANTI-ASSIGNMENT  
CLAUSES IN INSURANCE CONTRACTS**

This Bulletin sets out the Department's interpretation of North Carolina General Statute § 58-3200(d), as it relates to clauses in insurance contracts prohibiting the assignment of benefits to health care providers who are not under contract with the insurer.

Insurers' preferred provider benefit plans and health maintenance organizations' (HMOs) benefit plans, defined in North Carolina General Statutes §§ 58-50-56, 58-67-5 and 58-3-200, are health benefit plans in which enrollees are given incentives through differentials in deductibles, coinsurance or copayments to obtain covered services from health care providers who are under contract with the plan. Insurers offering network plans are required to maintain provider networks that are sufficiently accessible and available to meet their insureds' health care needs. Participating providers agree to accept payment for services from the health plan, collecting only the applicable deductible, coinsurance or copayment from the insured. Network plans may restrict or limit coverage for health care services obtained from non-participating providers and may include provisions in their insurance contracts prohibiting the assignment of benefits to non-participating providers.

Under North Carolina General Statute § 58-3-200 (d), insurers are prohibited from penalizing or subjecting insureds to out-of-network benefit levels when an insured receives covered services from a non-participating provider *because a participating provider was not reasonably available without unreasonable delay*. The statute refers to the application of penalties in general, as well as to different benefit levels that may be applied when the insured has elected to obtain services from a non-participating provider. Until recently, questions posed to the Department regarding the meaning of § 58-3-200 (d) focused on the insured's liability and insurer payment necessary to satisfy the provision regarding out-of-network benefit levels. Now, insurers and providers have

inquired about the Department's interpretation of penalties other than out-of-network benefit levels.

The clear intent of this statute is to prevent the insured from suffering any monetary or other penalty when services of a participating provider are not reasonably available without unreasonable delay. The enforcement of a non-assignment clause effectively subjects an insured to penalties when it causes the insured to make out-of-pocket payments in excess of the in-network deductible, coinsurance or copayment, while awaiting reimbursement from the insurer. Therefore, the Department has concluded that North Carolina General Statute § 58-3-200 (d) prohibits the enforcement of anti-assignment clauses in insurance contracts in cases where an insured must obtain services from a non-participating provider because a participating provider is not reasonably available without unreasonable delay, and where the enforcement would subject the insured to the penalties described above. Therefore, insurers are required to take steps to prevent insureds from being in the position of having to make payment at the time of service (other than applicable deductibles, copayment or coinsurance) and awaiting reimbursement, in cases where services are rendered by non-network providers because a network provider is not reasonably available without unreasonable delay.

The Department recognizes that some insurers' claims processing systems will require re-programming in order to comply with this directive (e.g. systems currently programmed to automatically generate payment to the insured when a claim is filed by a non-participating provider). In addition, some insurers may elect to modify their claims processing systems in order to facilitate the handling of these claims. Automated claims processing systems, however, cannot be programmed to accurately differentiate every claim for which assignment should be honored in accordance with this Bulletin, and consequently some claims will require investigation or manual processing. Policies and procedures governing both automated and manual claims processing will require the appropriate revisions. Finally, depending upon its current practices, an insurer may find it necessary to modify their policies and procedures with respect to pre-service authorizations, member services, appeals and grievances and perhaps other internal operations, in order to honor assignments as set out in this Bulletin.

Insurers are required to fully implement the operational changes necessary to comply with this directive by **August 23, 2002**. The Department will generally consider an insurer to be in compliance with this directive where it is evident the insurer has made good faith efforts to implement or modify its manual and/or automated claims processing systems, has instituted the appropriate underlying policies and procedures for recognizing valid assignments of benefits in accordance with this Bulletin, and is processing claims accordingly.



## Attachment I: Utilization Review Statutes

### § 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:

- (1) "Certificate of coverage" includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.
- (1a) "Clinical peer" means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.
- (2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.
- (3) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.
- (4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
  - a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
  - b. Serious impairment to bodily functions.
  - c. Serious dysfunction of any bodily organ or part.
- (5) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
- (6) "Grievance" means a written complaint submitted by a covered person about any of the following:
  - a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health

benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

- b. Claims payment or handling; or reimbursement for services.
  - c. The contractual relationship between a covered person and an insurer.
  - d. The outcome of an appeal of a noncertification under this section.
- (7) "Health benefit plan" means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
- a. Accident.
  - b. Credit.
  - c. Disability income.
  - d. Long-term or nursing home care.
  - e. Medicare supplement.
  - f. Specified disease.
  - g. Dental or vision.
  - h. Coverage issued as a supplement to liability insurance.
  - i. Workers' compensation.
  - j. Medical payments under automobile or homeowners.
  - k. Hospital income or indemnity.
  - l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- (8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.

- (9) "Health care services" means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- (10) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.
- (11) "Managed care plan" means a health benefit plan in which an insurer either (i) requires a covered person to use or (ii) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.
- (12) "Medically necessary services or supplies" means those covered services or supplies that are:
- a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
  - b. Except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
  - c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
  - d. Within generally accepted standards of medical care in the community.
  - e. Not solely for the convenience of the insured, the insured's family, or the provider.
- For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.
- (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 a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

- (14) "Participating provider" means a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.
- (15) "Provider" means a health care provider.
- (16) "Stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.
- (17) "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:
  - a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.
  - b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
  - c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
  - d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.
  - e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the



coordination and management of the care that a patient receives after discharge from a provider facility.

- f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.
- 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.
- h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

(18) "Utilization review organization" or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own health benefit plan.

(b) Insurer Oversight. – Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:

- (1) A written description of the URO's activities and responsibilities, including reporting requirements.
- (2) Evidence of formal approval of the utilization review organization program by the insurer.
- (3) A process by which the insurer evaluates the performance of the URO.

(c) Scope and Content of Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

- (1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.
- (2) Data sources and clinical review criteria used in decision making.
- (3) The process for conducting appeals of noncertifications.

- (4) Mechanisms to ensure consistent application of review criteria and compatible decisions.
- (5) Data collection processes and analytical methods used in assessing utilization of health care services.
- (6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.
- (7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.
- (8) The staff position functionally responsible for day-to-day program management.
- (9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

- (e) Insurer Responsibilities. – Every insurer shall:
- (1) Routinely assess the effectiveness and efficiency of its utilization review program.

- (2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
- (3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.
- (4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.
- (5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.
- (6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(f) **Prospective and Concurrent Reviews.** – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

(g) **Retrospective Reviews.** – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification.

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:

- (1) The professional qualifications and licensure of the person or persons reviewing the appeal.
- (2) A statement of the reviewers' understanding of the reason for the covered person's appeal.
- (3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
- (4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
- (5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.
- (6) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(l) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for

prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(n) Maintenance of Records. – Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(o) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-443, s. 11A.122; 1997-519, s. 4.1; 1999-116, s. 1; 1999-391, ss. 1-4; 2001-417, ss. 2-7; 2001-416, ss. 4.4, 5; 2003-105, s. 1; 2005-223, s. 8.)

### **§ 58-50-62. Insurer grievance procedures.**

(a) Purpose and Intent. – The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(b1) Informal Consideration of Grievances. – If the insurer provides procedures for informal consideration of grievances, the procedures shall be in writing, and the following requirements apply:

- (1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner;

- (2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in subsection (c) of this section; or
- (3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e)(1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance.

(c) **Grievance Procedures.** – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office. The description shall also inform the covered person about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(d) **Maintenance of Records.** – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for three years or until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) **First-Level Grievance Review.** – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

- (1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.
- (2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of

the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:

- a. The professional qualifications and licensure of the person or persons reviewing the grievance.
- b. A statement of the reviewers' understanding of the grievance.
- c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
- d. A reference to the evidence or documentation used as the basis for the decision.
- e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.
- f. Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

- (3) For grievances concerning the quality of clinical care delivered by the covered person's provider, the insurer shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the covered person that (i) the insurer will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.

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

- (1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
  - a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
  - b. A statement of a covered person's rights, which include the right to request and receive from an insurer all



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

c. The availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

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

(g) Second-Level Grievance Review Procedures. – An insurer's procedures for conducting a second-level grievance review shall include:

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.

(2) The covered person shall be notified in writing at least 15 days before the review meeting date.

(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

- (1) The professional qualifications and licensure of the members of the review panel.
- (2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
- (3) The review panel's recommendation to the insurer and the rationale behind that recommendation.
- (4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
- (5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
- (6) The rationale for the insurer's decision if it differs from the review panel's recommendation.
- (7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
- (8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.
- (9) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

(i) Expedited Second-Level Procedures. – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-519, s. 4.2; 2001-417, ss. 8-11; 2001-446, s. 4.6; 2003-105, s. 2(a)-(d).)

## **Attachment J: Silent PPO Statute**

### **§ 58-63-70. Health care service discount practices by insurers and service corporations.**

(a) It is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees.

## **Attachment K: Standard Insurance Identification Card Statute**

### **58-3-247. (Effective January 1, 2009) Insurance identification card.**

(a) Every insurer offering a health benefit plan as defined under G.S. 58-3-167, including the State Health Plan, shall provide the health benefit plan subscriber or members with an insurance identification card. The card shall contain at a minimum:

- (1) The subscriber's name and identification number.
- (2) The member's name and identification number, if applicable and different from the subscriber's name and identification number.
- (3) The group number.
- (4) The name of the organization issuing the policy, the name of the organization administering the policy, and the name of the network, whichever applies.
- (5) The effective date of health benefits plan coverage or the date the card is issued if it is after the effective date.
- (6) The address where claims are to be filed and, if applicable, the electronic claims filing payor identification number.
- (7) The policyholder's obligations with regard to co-payments, if applicable, for at least the following:
  - a. Primary care office visit.
  - b. Specialty care office visit.
  - c. Urgent care visit.
  - d. Emergency room visit.
- (8) The phone number or Web site address whereby the subscriber, member, or service provider, in compliance with privacy rules under the Health Insurance Portability and Accountability Act may readily obtain the following:
  - a. Confirmation of eligibility.
  - b. Benefits verification in order to estimate patient financial responsibility.
  - c. Prior authorization for services and procedures.
  - d. The list of participating providers in the network.
  - e. The employer group number.
  - f. Special mental health medical benefits under the health plan, if applicable.

(b) The insurance identification card must be designed such that if the card is photocopied or electronically scanned, the resulting image is clearly legible. The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology. (2007-362, s. 2.)

# Attachment L: North Carolina Department of Insurance Regulations re: Provider Contracts including Contracts with Intermediaries and Contract Checklist

## 11 NCAC 20 .0202 CONTRACT PROVISIONS

All contract forms that are created or amended on or after the effective date of this Section, and all contract forms that are executed later than six months after the effective date of this Section, shall contain provisions addressing the following:

- (1) Whether the contract and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties.
- (2) Definitions of technical insurance or managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in the evidence of coverage issued in conjunction with the network plan.
- (3) An indication of the term of the contract.
- (4) Any requirements for written notice of termination and each party's grounds for termination.
- (5) The provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations shall address:
  - (a) Transition of administrative duties and records.
  - (b) Continuation of care, when inpatient care is on-going. If the carrier provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- (6) The provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials.
- (7) The provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of professional liability insurance on a timely basis.
- (8) With respect to member billing:
  - (a) If the carrier provides or arranges for the delivery of health care services on a prepaid basis under G.S. 58, Article 67, the provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service.
  - (b) Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- (9) Any provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility.
- (10) The carrier's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the carrier, before rendering health care services. Mutually agreeable provision may be made for cases where incorrect or retroactive information was submitted by employer groups.
- (11) Provider requirements regarding patients' records. The provider shall:
  - (a) Maintain confidentiality of enrollee medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.
  - (b) Maintain adequate medical and other health records according to industry and carrier standards.

- (c) Make copies of such records available to the carrier and Department in conjunction with its regulation of the carrier.
- (12) The provider's obligation to cooperate with members in member grievance procedures.
- (13) A provision that the provider shall not discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.
- (14) Provider payment that describes the methodology to be used as a basis for payment to the provider (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus).
- (15) The carrier's obligations to provide data and information to the provider, such as:
  - (a) Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
  - (b) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing providers time to comply with such changes.
- (16) The provider's obligations to comply with the carrier's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- (17) The provider's authorization and the carrier's obligation to include the name of the provider or the provider group in the provider directory distributed to its members.
- (18) Any process to be followed to resolve contractual differences between the carrier and the provider.
- (19) Provisions on assignment of the contract shall contain:
  - (a) The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the carrier.
  - (b) The carrier shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

**11 NCAC 20 .0204 CARRIER AND INTERMEDIARY CONTRACTS**

- (a) If a carrier contracts with an intermediary for the provision of a network to deliver health care services, the carrier shall file with the Division for prior approval its form contract with the intermediary. The filing shall be accompanied by a certification from the carrier that the intermediary will, by the terms of the contract, be required to comply with all statutory and regulatory requirements which apply to the functions delegated. The certification shall also state that the carrier shall monitor such compliance.
- (b) A carrier's contract form with the intermediary shall state that:
  - (1) All provider contracts used by the intermediary shall comply with, and include applicable provisions of, 11 NCAC 20 .0202.
  - (2) The network carrier retains its legal responsibility to monitor and oversee the offering of services to its members and financial responsibility to its members.
  - (3) The intermediary may not subcontract for its services without the carrier's written permission.
  - (4) The carrier may approve or disapprove participation of individual providers contracting with the intermediary for inclusion in or removal from the carrier's own network plan.
  - (5) The carrier shall retain copies or the intermediary shall make available for review by the Department all provider contracts and subcontracts held by the intermediary.
  - (6) If the intermediary organization assumes risk from the carrier or pays its providers on a risk basis or is responsible for claims payment to its providers:
    - (A) The carrier shall receive documentation of utilization and claims payment and maintain accounting systems and records necessary to support the arrangement.
    - (B) The carrier shall arrange for financial protection of itself and its members through such approaches as member hold harmless language, retention of

signatory control of the funds to be disbursed, or financial reporting requirements.

(C) To the extent provided by law, the Department shall have access to the books, records, and financial information to examine activities performed by the intermediary on behalf of the carrier. Such books and records shall be maintained in the State of North Carolina.

(7) The intermediary shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by the carrier and assumed by the intermediary.

(c) If a carrier contracts with an intermediary to provide health care services and pays that intermediary directly for the services provided, the carrier shall either monitor the financial condition of the intermediary to ensure that providers are paid for services, or maintain member hold harmless agreements with providers.

For NCDOT Provider/Intermediary Contract Compliance Checklist:

See: <http://www.ncdoi.com/LH/Documents/Checklists/ProviderIntermediary.xls>

## **Attachment M: Statutes related to Insurers, Preferred Provider Organizations and Preferred Provider Benefit Plans**

### **§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.**

(a) Definitions. – As used in this section:

- (1) "Insurer" means an insurer or service corporation subject to this Chapter.
- (2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives.
- (3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers.
- (4) "Preferred provider organization" or "PPO" means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A preferred provider contract or other cost containment arrangement that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently,



may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. G.S. 58-50-30 applies to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

(f) Every insurer offering a preferred provider benefit plan and contracting with a PPO shall require by contract that the PPO shall provide all of the preferred providers with whom it holds contracts information about the insurer and the insurer's preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:

- (1) Accessibility of preferred provider services to individuals within the insured group.
- (2) The adequacy of the number and locations of health care providers.
- (3) The availability of services at reasonable times.
- (4) Financial solvency.

(h) Each insurer offering a preferred provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall disclose annually the following information:

- (1) The name by which the preferred provider benefit plan is known and its business address.
- (2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.
- (3) The terms of the agreements entered into by the insurer with preferred providers.
- (4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt

rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers. (1997-443, s. 11A.122; 1997-519, s. 3.1; 1998-211, s. 2; 1999-210, s. 3; 2001-297, s. 3; 2001-334, s. 2.1.)

## **Attachment N: Statutes related to State Employee Health Plan**

*See: NCGS Chapter 135: Retirement System for Teachers and State Employees; Social Security; Health Insurance Program for Children*  
<http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl?Chapter=0135>