§ 108D-14. Expedited managed care entity level appeals.

(a) Request for Expedited Appeal. – When the time limits for completing a standard managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the enrollee's authorized representative, has the right to file a request for an expedited appeal of an adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request for an expedited managed care entity level appeal, then (i) the managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by mail no later than 72 hours after receiving the request for an expedited appeal and (ii) the managed care entity shall resolve the appeal within the time limits established for standard managed care entity level appeals in G.S. 108D-13. The denial is not appealable.

(c) Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an expedited managed care entity level appeal to the extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – If the managed care entity grants a request for an expedited managed care entity level appeal, the managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than 72 hours after receiving the request for an expedited appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by mail within this 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f). (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, s. 2.2(f), (g); 2022-74, s. 9D.15(u).)