RULES AND REGULATIONS OF

THE INSURANCE COMMISSIONER

CHAPTER 120-2-111

PATIENT'S RIGHT TO INDEPENDENT REVIEW

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(1) "Act" means O.C.G.A. § 33-20A-30 *et seq.*, which shall be known and cited as the "Patient's Right to Independent Review Act."

(2) "Adverse Outcome" means a decision issued by a managed care entity to an eligible enrollee after the grievance procedure provided for in O.C.G.A. § 33-20A-5, which was a denial of the claim in whole or in part of the eligible enrollee or a refusal to pay for a treatment sought.

(3) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(4) "Applicant" means a party that seeks approval from the Department to be certified as an independent review organization, or to have a previous certification renewed.

(5) "Commissioner" means the Commissioner of the Georgia Department of Insurance.

(6) "Dental Plan" means an insurance policy or health benefit plan, including a policy written by a company subject to the provisions of O.C.G.A. § 33-20A-1 *et seq.* that provides coverage for expenses for dental services.

(7) "Dentist" means a licensed doctor of dentistry holding either a D.D.S. or a D.M.D. degree.

(8) "Department" means the Department of Insurance.

(9) "Eligible Enrollee" means a person who:

> **(a)** Is an enrollee or an eligible dependent of an enrollee of a managed care plan or was an enrollee or an eligible dependent of an enrollee of such plan at the time of the request for treatment and,
>
> **(b)** Seeks a treatment which reasonably appears to be a covered service or benefit under the enrollee's evidence of coverage; provided, however, that this subparagraph shall not apply if the notice from a managed care plan of the outcome of the grievance procedure was that a treatment is experimental.

(10) "Emergency Services" or "Emergency Care" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(11) "Expert reviewer" means a person assigned by the independent review organization to review a request, and whose qualifications are consistent with the criteria as set forth in the Act and/or this Rule.

(12) "Grievance Procedure" means the internal grievance procedure of a managed care entity established for that entity pursuant to O.C.G.A. § 33-20A-5.

(13) "Health Benefit Plan" means a plan of benefits that defines the coverage provisions for health care offered or provided by any organization, public or private, other than health insurance.

(14) "Health Care Provider" or "provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, occupational therapist, speech language pathologist, audiologist, dietician, or physician's assistant.

(15) "Health Insurance Policy" means an insurance policy, including a policy subject to the provisions of O.C.G.A. § 33-20A *et seq.*, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(16) "Independent Review" means a system of administrative appeal an eligible enrollee is entitled to receive when any of the conditions set forth in Rule 120-2-111-.04 have been met.

(17) "Independent Review Organization" means any organization certified as such by the State Health Planning Agency or its successor Agency, the Department of Insurance, pursuant to O.C.G.A. § 33-20A-39.

(18) "Independent Review Plan" means the screening criteria and review procedures of an independent review organization.

(19) "Managed Care Entity" includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

(20) "Managed Care Plan" means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers and,

(c) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term "managed care plan" does not apply to Chapter 9 of Title 34, relating to workers' compensation.

(21) "Medical and Scientific Evidence" means:

(a) Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

(c) Medical journals recognized by the United States Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

(d) The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; or

(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(22) "Medical Necessity", "Medically Necessary Care", or "Medically Necessary and Appropriate" means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

(a) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

(b) Compatible with the standards of acceptable medical practice in the United States;

(c) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

(d) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

(e) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

(23) "Nurse" means a registered nurse.

(24) "Open Records Act" means the provisions codified in O.C.G.A. § 50-18-70 *et seq.*, including those provisions to be effective on July 1, 1999.

(25) "Out of Network" or "Point of Service" refers to health care items or services provided to an eligible enrollee by providers who do not belong to the provider network in the managed care plan.

(26) "Patient" means a person who seeks or receives health care services under a managed care plan.

(27) "Person" means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.

(28) "Physician" means a licensed doctor of medicine or a doctor of osteopathy.

(29) Reserved.

(30) "Provider of Record" means the physician or other health care provider that has primary responsibility for the care, treatment, and services requested on behalf of the patient and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

(31) "Receipt" means the date of the taking of actual physical possession of an item sent, or the date evidencing such possession by the normal and customary confirmation available for facsimile transmissions, other computer assisted electronic transmissions, courier delivery services, private delivery services, and the U.S. Mail service.

(32) "Screening Criteria" means the written policies, medical protocols, or guidelines used by the independent review organization as part of the independent review process.

(33) "Treatment" means a medical service, diagnosis, procedure, therapy, drug, or device.

(34) "Working Day" means a weekday, excluding any officially designated State holiday.

Authority: O.C.G.A. Sections 33-2-9 & 33-20A-41.