RULES AND REGULATIONS OF

THE INSURANCE COMMISSIONER

CHAPTER 120-2-111

PATIENT'S RIGHT TO INDEPENDENT REVIEW

TABLE OF CONTENTS

120-2-111-.04 Request for Independent Review

An eligible enrollee shall be entitled to appeal to an independent review organization when:

(1) The eligible enrollee has received notice of an adverse outcome pursuant to a grievance procedure or the managed care entity has not complied with the requirements of Code Section 33-20A-5 with regard to such procedures; or

(2) A managed care entity determines that a proposed treatment is excluded as experimental under the managed care plan, and all of the following criteria are met:

a. The eligible enrollee has a terminal condition that, according to the treating physician, has a substantial probability of causing death within two years from the date of the request for independent review or the eligible enrollee's ability to regain or maintain maximum function, as determined by the treating physician, would be impaired by withholding the experimental treatment;

b. After exhaustion of standard treatment as provided by the evidence of coverage or a finding that such treatment would be of substantially lesser or of no benefit, the eligible enrollee's treating physician certifies that the eligible enrollee has a condition for which standard treatment would not be medically indicated for the eligible enrollee or for which there is no standard treatment available under the evidence of coverage of the eligible enrollee more beneficial than the treatment proposed;

c. The eligible enrollee's treating physician has recommended and certified in writing treatment which is likely to be more beneficial to the eligible enrollee than any available standard treatment;

d. The eligible enrollee has requested a treatment as to which the eligible enrollee's treating physician, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the eligible enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols, such as control group or double-blind testing, published in peer reviewed literature, demonstrate that the proposed treatment is likely to be more beneficial for the eligible enrollee than available standard treatment; and

e. A specific treatment recommended would otherwise be included within the eligible enrollee's certificate of coverage, except for the determination by the managed care entity that such treatment is experimental for a particular condition.

(3) The Department shall determine that an eligible enrollee is entitled to independent review because of the managed care entity's failure to comply with the requirements of Code

Section 33-20A-5 if the managed care entity has failed to grant appropriate relief without delay after a determination favorable to the eligible enrollee; has failed to provide notice meeting the requirements of the Code Section to the eligible enrollee of the outcome of the grievance procedure within 60 days from the date of the grievance request, or 30 days where the grievance involves a case where the requested care or service has not been rendered, or in the case of an eligible enrollee who meets the requirements of Rule 111-2-3-.06(8) [Code Section 33-20A-37(c)], the managed care entity has failed to notify the eligible enrollee of the outcome of the grievance procedure within 72 hours from the date of the grievance request; or has otherwise failed to comply with the Code Section in question.

(4) The following additional criteria, in accordance with the Act, shall be required for independent review:
    a. Except where required pursuant to Code Section 51-1-49, a proposed treatment must require the expenditure of a minimum of $500.00 to qualify for independent review, provided that the minimum $500.00 expenditure shall include the full cost during the course of treatment of the items and services furnished by all providers and shall include the cost to the managed care entity and/or any provider at risk for the cost and any cost sharing by the eligible enrollee.
    b. The parent or guardian of a minor who is an eligible enrollee may act on behalf of the minor in requesting independent review. The legal guardian or representative of an incapacitated eligible enrollee shall be authorized to act on behalf of the eligible enrollee in requesting independent review. Except as provided in Code Section 51-1-49, independent review may not be requested by persons other than the eligible enrollee or a person acting on behalf of the eligible enrollee as provided in these Rules in accordance with the Act.
    c. A managed care entity shall be required to pay the full cost of applying for and obtaining the independent review, including the flat fee rate plus any ancillary costs as outlined in these Rules.
    d. The eligible enrollee and the managed care entity shall cooperate with the independent review organization to provide the information and documentation, including executing necessary releases for medical records, which are necessary for the independent review organization to make a determination of the claim.

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