RULES AND REGULATIONS OF

THE INSURANCE COMMISSIONER

CHAPTER 120-2-111

PATIENT'S RIGHT TO INDEPENDENT REVIEW

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(1) Within three working days of receipt of notice from the Department of assignment of the request for independent review, the managed care entity shall submit to that organization the following:

(a) Any information submitted to the managed care entity by the eligible enrollee or his/her provider in support of the eligible enrollee's grievance procedure filing;

(b) A copy of the contract provisions or evidence of coverage of the managed care plan, including the entire contract or policy; and

(c) Any other relevant documents or information used by the managed care entity in determining the outcome of the eligible enrollee's grievance.

(2) Upon request, the managed care entity shall provide a copy of all documents required by these Rules, except for any proprietary or privileged information, to the eligible enrollee, or the eligible enrollee's applicable representative. The eligible enrollee, or the eligible enrollee's applicable representative, may provide the independent review organization with any additional information the eligible enrollee may deem relevant. Proprietary or privileged information shall not include screening criteria or any procedure, studies, documents, communications, or any other information used by the managed care entity in making a determination in the eligible enrollee's case.

(3) The independent review organization shall request any additional information required for the review from the managed care entity and the eligible enrollee, or the eligible enrollee's applicable representative, within five working days of receipt of the documentation required under these Rules as outlined above. Any additional information requested by the independent review organization shall be submitted within five working days of receipt of the request, or an explanation of why the additional information is not being submitted shall be provided. In no case shall a managed care entity or an eligible enrollee, or an eligible enrollee's applicable representative, receive any more than an extension of ten working days to submit the required additional information. It shall not be grounds for a managed care entity to refuse to supply or to delay submission to the independent review organization any medical record based on an assertion by the managed care entity, or a provider or facility with which the managed care entity has a contract, that said records are then incomplete or un-reviewed.

(4) Additional information obtained from the eligible enrollee, or the eligible enrollee's applicable representative, shall be transmitted to the managed care entity, which may determine

that such additional information justifies a reconsideration of the outcome of the grievance procedure. A decision by the managed care entity to cover fully the treatment in question upon reconsideration using such additional information shall terminate independent review. The managed care entity shall notify the eligible enrollee, or the eligible enrollee's representative, the Department, and the independent review organization when such a decision is made. Upon such notification, the independent review organization shall not terminate its review until it has determined that the managed care entity's decision constitutes full coverage of the treatment in question. If the independent review organization determines that the managed care entity's decision does not constitute full coverage of the treatment in question, the eligible enrollee shall not be required to make a new request for independent review, and the managed care entity shall be bound by the entire independent review process both before and after any decision it made to offer coverage.

(5) The expert reviewer of the independent review organization shall make a determination within 15 working days after expiration of all additional information time limits set forth in these Rules, but such time limits may be extended or shortened by mutual agreement between the eligible enrollee, or the eligible enrollee's applicable representative, and the managed care entity subject to the provisions outlined above. The determination by the expert reviewer of the independent review organization shall be in writing and shall state the basis of the reviewer's decision. The determination shall contain the specific findings of fact, regulation, and policy, the basis and reasons thereof, and copies of the documents, studies, and all other information utilized and relied upon by the expert reviewer and the independent review organization in reaching its determination. A copy of the decision shall be delivered to the managed care entity, the eligible enrollee, the eligible enrollee's applicable representative, and the Department by Certified Mail, Return Receipt Requested.

(6) The independent review organization's decision shall be based upon a review of the information and documentation submitted to it.

(7) Information required or authorized to be provided pursuant to these Rules may be provided by facsimile transmission, and/or electronic mail if feasible for both sender and receiver. For purpose of any time deadline for the receipt of information in accordance with these Rules and the Act, the date of receipt by mail shall be the postmark date on the item(s) being sent, however this provision with regard to mailing does not supersede any applicable time deadline heretofore specified in the Act or these Rules.

(8) In the event that, in the judgment of the treating health care provider, the health condition of the eligible enrollee is such that following the procedure provisions outlined herein would jeopardize the life or health of the eligible enrollee or the eligible enrollee's ability to regain maximum function, as determined by the treating health care provider, an expedited review shall be available. The expedited review process shall encompass all applicable provisions outlined in these Rules, provided, however, that a decision by the expert reviewer shall be rendered within 72 hours (three calendar days) after the expert reviewer's receipt of all available requested documentation.

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