Subject 120-2-58 CERTIFICATION OF PRIVATE REVIEW AGENTS

Rule 120-2-58-.01 Purpose

The Purpose of this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance is to promote the delivery of quality health care by cost-effective means, efficient communication, protection of parties involved, accessible treatment done in a timely and effective manner, maintaining confidentiality of information, and to provide minimum standards for private review agents.

Rule 120-2-58-.02 Definitions

(1) "Adverse Determination" means a determination based on medical necessity made by a private review agent or utilization review entity not to ~~certify~~ grant authorization to a hospital, ~~or~~ surgical or other facility admission, extension of a hospital stay or other health care service or procedure based on medical necessity or appropriateness.

(2) "Appeal" means a formal request, either orally, or in writing or by electronic transmission, to a private review agent to reconsider a determination not to certify an admission, extension of stay, or other health care service or procedure.

(3) Authorization: ' means a determination by a private review agent or utilization review entity that a healthcare service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity.

(4) Claim Administrator: ' means any entity that reviews and determines whether to pay claims to covered persons on behalf of the healthcare plan. Such payment determinations are made on the basis of contract provisions including medical necessity and other factors. Claim administrators may be insurers or their designated review organization, self-insured employers, management firms, third-party administrators, or other private contractors.

(5) Clinical Criteria: ' means the written policies, decisions, rules, medical protocols, or guidelines used by a private review agent or utilization review entity to determine medical necessity.

(6) Clinical Peer: means a healthcare provider who is licensed without restriction or otherwise legally authorized and currently in active practice in the same or similar specialty as that of the treating provider, and who typically manages the medical condition or disease at issue and has knowledge of and experience providing the healthcare service or treatment under review.

(7) "Complaint" is a communication either orally, in writing or by electronic transmission concerning matters related to utilization review including, but not limited to, health care services, denials, accessibility, and confidentiality.

(8) Covered Perso: means an individual, including, but not limited to, any subscriber, enrollee, member, beneficiary, participant, or his or her dependent, eligible to receive healthcare benefits by a health insurer pursuant to a healthcare plan or other health insurance coverage.

(9) "Concurrent Review" means utilization review conducted during a patient's hospital stay or course of treatment.

(10) Emergency healthcare services means healthcare services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of 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) Facility means a hospital, ambulatory surgical center, birthing center, diagnostic and treatment center, hospice, or similar institution. Such term shall not mean a healthcare provider's office.

(12) 'Health insurer' or 'insurer' means an accident and sickness insurer, care management organization, healthcare corporation, health maintenance organization provider sponsored healthcare corporation, or any similar entity regulated by the Commissioner.

(13) 'Healthcare plan' means any hospital or medical insurance policy or certificate, qualified higher deductible health plan, stand-alone dental plan, health maintenance organization or other managed care subscriber contract, the state health benefit plan, or any plan entered into by a care management organization as permitted by the Department
of Community Health for the delivery of healthcare services.

(14) 'Healthcare service' means healthcare procedures, treatments, or services provided by a facility licensed in this state or provided within the scope of practice of a doctor of medicine, a doctor of osteopathy, or another healthcare provider licensed in this state. Such term includes but is not limited to the provision of pharmaceutical products or services or durable medical equipment.

(15) 'Medical necessity' or 'medically necessary' means healthcare services that a prudent physician or other healthcare provider would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a manner that is:
(A) In accordance with generally accepted standards of medical or other healthcare practice;
(B) Clinically appropriate in terms of type, frequency, extent, site, and duration;
(C) Not primarily for the economic benefit of the health insurer or for the convenience of the patient, treating physician, or other healthcare provider; and
(D) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan.

(16) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. Such term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the

performance of pharmacy benefits management for a healthcare plan. Such term shall not include services provided by pharmacies operating under a hospital pharmacy license. Such term shall not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. Such term shall not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(17) 'Prior authorization' means any written or oral determination made at any time by a claim administrator or an insurer, or any agent thereof, that a covered person's receipt of healthcare services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. The term 'agent' as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(18) 'Private review agent' means any person or entity which performs utilization review for:
(A) An employer with employees who are treated by a health care healthcare provider in this state;
(B) A payor An insurer; or
(C) A claim administrator.

(19) "Reconsideration" means a request either orally, in writing or by electronic transmission to the private review agent to reconsider an adverse determination.

(20) "Review Criteria" means the written policies, decisions, rules, medical protocols or guidelines used by the private review agent to determine medical necessity or appropriateness.

(21)'Urgent healthcare service' means a healthcare service with respect to which the application of the time periods for making a nonexpedited prior authorization, which, in the opinion of a physician or other healthcare provider with knowledge of the covered person's medical condition:
(A) Could seriously jeopardize the life or health of the covered person or the ability of such person to regain maximum function; or
(B) Could subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. Such term shall include services provided for the treatment of substance use disorders which otherwise qualify as an urgent healthcare service.

(22) "Utilization Review Determination" means a recommendation by a private review agent regarding medical necessity or appropriateness of the health care services given or proposed to be given to a patient.

Rule 120-2-58-.03 Application and Renewal Filing Requirements

(1) Applications for certification shall be submitted to the Office of the Commissioner of Insurance on Forms GID-57, GID-65(UR) and GID-72, attached hereto and incorporated herein, along with the original license or certificate fee and application fee required for private review agents under O.C.G.A. 33-8-1.

(2) Private review agents operating in Georgia prior to the effective date of this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance and which have not applied for certification within sixty (60) days of such effective date shall be in violation of Chapter 46 of Title 33 of the Official Code of Georgia Annotated and this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance and are prohibited from operating as a private review agent until such private review agent has applied for certification and has been certified.

(3) a. Any private review agent not operating in Georgia on the effective date of this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance may apply for certification at any time prior to doing business in Georgia.

b. A private review agent or utilization review entity may not conduct utilization review of ~~health care~~ healthcare provided in this state unless the Commissioner has granted the private review agent or utilization review entity a certificate pursuant to this chapter.

(4) A certificate shall expire on the second anniversary of its effective date unless renewed, suspended or revoked. Renewal for an additional two (2) year term may be applied for no sooner than ninety (90) days prior to the certification expiration date. Application for renewal shall be submitted on Forms GID-57, GID-65(UR) and GID-72 with the renewal license or certificate fee of $500 required for private review agents under O.C.G.A. § 33-8-1.

(5) On initial application for certification, all advertising materials to be used in Georgia by private review agents shall be filed with the Office of the Commissioner of Insurance.

(6) Each application for certification or renewal must include the following:

(a) A utilization review plan;

(b) Documentation that the private review agent has received full accreditation or certification by the Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA). Reason or reasons should be stated if the organization is not presently fully accredited or certified by URAC or NCQA.

(c) The type, qualifications and number of the personnel, either employed or under contract, to perform the utilization review;

(d) A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan;

(e) A written description of an ongoing quality assessment program;

(f) The written policies and procedures to ensure that an appropriate representative of the private review agent is reasonably accessible to patients and health care providers five (5) days a week during normal business hours in this State;

(g) The written policies and procedures to ensure that information obtained in the course of utilization review is maintained in a confidential manner. Such policies and procedures shall include, but not be limited to, the following:

1. Assurances that information obtained during the process of utilization review will be kept confidential in accordance with any applicable state or federal laws and regulations;

2. Assurances that the information collected for purposes of utilization review will be limited to the information necessary for the claims administrator to adjudicate the claim and used solely for the purposes of utilization review, quality management, discharge planning and case management;

3. Assurances that information obtained for purposes of utilization review will be shared only with those agents (such as the claims administrator) who have authority to receive such information;

4. Guidelines to prevent unauthorized release of individual enrollee information to the public. Information pertaining to the diagnosis, treatment or health of an enrollee shall be disclosed only to authorized persons. Release of information otherwise shall only be permitted with the express written consent of the covered enrollee, or pursuant to court order for the production of evidence or discovery, or as otherwise provided by state or federal law.

(h) The written policies and procedures establishing and maintaining a complaint system; and

(i) A sample John Doe copy of each type of contract or agreement to be executed between the private review agent and payor, employer, claim administrator, or other entity with certification that the private review agent shall not enter into any incentive payment provision contained in a contract or agreement with a payor which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization or alternative treatment settings to reduce amounts of necessary or appropriate medical care.

Rule 120-2-58-.04 Refusal, Suspension and Revocation

The Office of Commissioner of Insurance may refuse to issue or renew and may suspend or revoke a certificate if a private review agent:

(a) Violates any provision or otherwise fails to comply with any provision of Chapter 46 of Title 33 of the Official Code of Georgia Annotated or this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance;

(b) Has intentionally misrepresented or concealed any material fact in any application for certification or on any form filed with the Commissioner of Insurance;

(c) Has obtained or attempted to obtain the certification by misrepresentation, concealment, or other fraud or uses a certification without proper authority; or

(d) Has failed to produce records in response to a written request by the Office of Commissioner of Insurance sent to the last known address of the private review agent.

Rule 120-2-58-.05 Requirements for Utilization Review

(1) Private review agents shall have sufficient staff to facilitate review in accordance with review criteria and shall designate one or more individuals able to effectively communicate medical and clinical information.

(2) Private review agent shall provide access to its review staff by a toll free or collect call telephone line during normal business hours. A private review agent shall have an established procedure to review timely call backs from health care providers and shall establish written procedures for receiving after-hour calls, either in person or by recording.

(3) Private review agent shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services. All requests for information shall be made during normal business hours.

(4) Private review agents shall identify themselves prior to collecting necessary information.

(5) Private review agents shall establish and follow procedures and rules for on-site medical facility review.

(6) In the event a private review agent questions the medical necessity or appropriateness of care, the following procedures will apply:

(a) The attending health care provider shall have the opportunity to discuss a utilization review determination promptly by telephone with a clinical peer, an identified health care provider representing the private review agent and trained in a related medical specialty. If the determination is made not to certify, an adverse determination exists.
~~33-46-6,~~ 33-46-26

(b) Reconsideration of an adverse determination occurs when any questions concerning medical necessity or appropriateness of care are not resolved under subparagraph (a) above. The right to appeal an adverse determination shall be available to the enrollee and the attending physician or other ordering health care provider. The enrollee or enrollee's representative shall be allowed a second review by another identified health care provider in an appropriate medical specialty who represents the private review agent.

(7) The private review agent shall have written procedures for providing notification of its determinations regarding all forms of certification in accordance with the following:

(a) When an initial determination is made to certify, notification shall be provided promptly either by telephone, in writing or electronic transmission to the attending health care provider, the facility rendering service as well as to the enrollee. Written notification shall be transmitted within two (2) business days of the determination.

(b) When a determination is made not to certify, the attending physician and/or other ordering health care provider or facility rendering service shall:

1. Be notified by telephone within one (1) business day.

2. Be sent a written notification within one (1) business day, which also shall be sent to the enrollee. The written notification shall include: principal reason(s)

for the determination and instructions for initiating an appeal of the adverse determination.

(c) The private review agent shall establish procedures for appeals to be made in writing and by telephone. The private review agent shall notify the health care provider and enrollee in writing of its determination on the appeal as soon as possible, but in no case later than sixty ~~(60)~~ (15) days after receiving the required documentation to conduct the appeal~~.~~ in calendar year 2022, and within (7) calendar days in 2023.

(d) The appeals procedure does not preclude the right of an enrollee to pursue legal action.

Rule 120-2-58-.06 Complaint Procedure

Private review agents shall establish and maintain a complaint system which includes, at a minimum, the following:

(~~a~~1) All complaints shall be directed to the private review agent; and

(~~b~~2) The private review agent shall contact the complainant, gather all pertinent facts regarding the complaint, and attempt to resolve the complaint as soon as reasonably possible within the context of written policies and procedures.

(3) a. Establishes and maintains a complaint system which has been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints initiated by enrollees covered persons or health care healthcare providers concerning utilization review;

b. Maintains records of such written complaints for five years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require; and

c. Permits the Commissioner to examine the complaints at any time

Rule 120-2-58-.07 Reporting Requirements

(1) By March 1, ~~1997~~ 2023, and annually thereafter on or before the same date, each private review agent shall submit to the Office of the Commissioner of Insurance a list of all complaints by type and disposition, and an analysis of such complaints files against them during the past calendar year.

(2) By March 1, ~~1997~~ 2023, and annually thereafter on or before the same date, the annual report information regarding utilization review activities for the preceding calendar year shall be submitted to the Office of Commissioner of Insurance on Form GID-73 which is attached hereto and incorporated herein.

(3) The Commissioner of Insurance shall require any other reporting requirements that are necessary to fully evaluate utilization review compliance with Chapter 46 of Title 33 of the Official Code of Georgia Annotated and this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance and the impact of utilization review programs on patient access to care.

(4) Each private review agent shall notify the Office of Commissioner of Insurance in writing within sixty (60) days of any changes to information last filed with the Office of Commissioner of Insurance under Form GID-57.

Rule 120-2-58-.08 Penalties

Any certified private review agent which violates or fails to comply with any provision of Chapter 46 of Title 33 of the Official Code of Georgia Annotated and this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its certification or right to do business in this state.

Rule 120-2-58-.09 Severability Provision

If any rule or portion of a rule in this Chapter of the Rules and Regulations of the Office of Commissioner of Insurance or the applicability thereof to any particular person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the rules or the applicability of such provisions to other persons or circumstances shall not be affected thereby.
~~**JOHN W. OXENDINE**~~