Senate Bill 215

By: Senator Tarver of the 22nd

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for an independent review of certain health insurance decisions; to provide for definitions; to provide for review criteria; to provide for limitations; to provide for procedures; to provide for requirements of an independent review organization; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"CHAPTER 20C

33-20C-1.

As used in this chapter, the term:

(1) 'Department' means the Department of Community Health established under Chapter 5A of Title 31.

(2) 'Enrollee' means the individual who has elected to contract for or participate in a health benefit plan for himself or herself or both himself or herself and his or her eligible dependents.

(3) 'Health benefit plan' means a plan of benefits that defines the coverage provisions for health care for enrollees offered or provided by any organization, public or private.

(4) 'Health care provider' means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing health care services, including, but not limited to, a doctor of medicine, doctor of osteopathy, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist,

psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker.

(5) 'Independent review organization' means any organization certified as such by the department under Code Section 33-20A-39.

(6) '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* or Excerpta Medica (EMBASE), MEDLINE, MEDLARS, or Health Services Technology Assessment Research (HSTAR) data bases;

(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, the Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) 'Payor' means any insurer, as defined in this title, or any preferred provider organization, health maintenance organization, self-insurance plan, or other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health care benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract of accident and sickness insurance as defined in Code Section 33-7-2.

(8) 'Treatment' means a medical service, diagnosis, procedure, therapy, drug, or device.

33-20C-2.

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

(1) The enrollee has received notice of denial for a covered service or therapy or any limitation of such covered service or therapy; or

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

(A) The 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 enrollee's ability to regain or maintain maximum function, as determined by the treating physician, would be impaired by withholding such 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 enrollee's treating physician certifies that the enrollee has a condition for which standard treatment would not be medically indicated for the enrollee or for which there is no standard treatment available under the evidence of coverage of the enrollee more beneficial than the treatment proposed;

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

(D) The enrollee has requested a treatment as to which the 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 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 enrollee than available standard treatment; and

(E) A specific treatment recommended would otherwise be included within the enrollee's certificate of coverage, except for the determination by the payor that such treatment is experimental for a particular condition.

33-20C-3.

Except where required pursuant to Code Section 51-1-49, a proposed treatment shall require the expenditure of a minimum of $500.00 to qualify for independent review.

33-20C-4.

(a) The parent or guardian of a minor who is an enrollee may act on behalf of such minor in requesting independent review. The legal guardian or representative of an incapacitated enrollee shall be authorized to act on behalf of such enrollee in requesting independent review. Except as provided in Code Section 51-1-49, independent review shall not be

requested by persons other than the enrollee or a person acting on behalf of the enrollee as provided in this Code section.

(b) A payor shall be required to pay the full cost of applying for and obtaining the independent review.

(c) The enrollee and the payor 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.

33-20C-5.

(a) The payor shall include with the written notice of denial of service a statement specifying that any request for independent review must be made to the department on forms developed by the department, and such forms shall be included with the notification. Such statement shall be in simple, clear language in boldface type which is larger and bolder than any other typeface which is in the notice and in at least 14 point typeface.

(b) An enrollee shall submit the written request for independent review to the department. Instructions on how to request independent review shall be given to all enrollees with the written notice required under this Code section together with instructions in simple, clear language as to what information, documentation, and procedures are required for independent review.

(c) Upon receipt of a completed form requesting independent review as required by subsection (a) of this Code section, the department shall notify the enrollee of receipt and assign the request to an independent review organization on a rotating basis according to the date the request is received.

(d) Upon assigning a request for independent review to an independent review organization, the department shall provide written notification of the name and address of the assigned independent review organization to both the requesting enrollee and the payor.

(e) No payor shall be licensed by the Commissioner of Insurance under this title unless the payor agrees to pay the costs of independent review to the independent review organization assigned by the department to conduct each review involving such payor's enrollees.

33-20C-6.

(a) Within three business days of receipt of notice from the department of assignment of the application for determination to an independent review organization, the payor shall submit to that independent review organization:

(1) Any information submitted to the payor by the enrollee in support of the enrollee's claim;

(2) A copy of the contract provisions or evidence of coverage of the health benefit plan; and

(3) Any other relevant documents or information used by the payor in determining the outcome of the enrollee's denied claim.

Upon request, the payor shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the enrollee. The enrollee may provide the independent review organization with any additional information the enrollee deems relevant.

(b) The independent review organization shall request any additional information required for the review from the payor and the enrollee within five business days of receipt of the documentation required under this Code section. Any additional information requested by the independent review organization shall be submitted within five business days of receipt of the request, or an explanation of why the additional information is not being submitted shall be provided.

(c) Additional information obtained from the enrollee shall be transmitted to the payor, which may determine that such additional information justifies a reconsideration of the outcome of the denial. A decision by the payor to cover fully the treatment in question upon reconsideration using such additional information shall terminate the independent review.

(d) The expert reviewer of the independent review organization shall make a determination within 15 business days after expiration of all time limits set forth in this Code section, but such time limits may be extended or shortened by mutual agreement between the enrollee and the payor. The determination shall be in writing and shall state the basis of the reviewer's decision. A copy of the decision shall be delivered to the payor, the enrollee, and the department by at least first-class mail.

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

(f) Information required or authorized to be provided pursuant to this Code section may be provided by facsimile transmission or other electronic transmission.

33-20C-7.

(a) A decision of the independent review organization in favor of the enrollee shall be final and binding on the payor, and the appropriate relief shall be provided without delay. A payor bound by such decision of an independent review organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such decision. Nothing in this Code section shall relieve the payor from liability for damages proximately caused by its determination of the proposed treatment prior to such decision.

(b) A determination by the independent review organization in favor of a payor shall create a rebuttable presumption in any subsequent action that the payor's prior determination was appropriate and shall constitute a medical record for purposes of Code Section 24-7-8.

(c) In the event that, in the judgment of the treating health care provider, the health condition of the enrollee is such that following the provisions of Code Section 33-20C-6 would jeopardize the life or health of the enrollee or the 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 elements enumerated in Code Sections 33-20C-6, 33-20C-10, and 33-20C-11; provided, however, that a decision by the expert reviewer shall be rendered within 72 hours after the expert reviewer's receipt of all available requested documents.

33-20C-8.

Neither an independent review organization nor its employees, agents, or contractors shall be liable for damages arising from determinations made pursuant to this chapter, unless an act or omission thereof is made in bad faith or through gross negligence, constitutes fraud or willful misconduct, or demonstrates malice, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to the consequences.

33-20C-9.

(a) The department shall certify independent review organizations that meet the requirements of this Code section and any regulations promulgated by the department consistent with this chapter. The department shall deem certified any independent review organization meeting standards developed for this purpose by an independent national accrediting organization. To qualify for certification, an independent review organization shall be subject to the following conditions:

(1) Expert reviewers assigned by the independent review organization shall be physicians or other appropriate health care providers who meet the following minimum requirements:

(A) Are expert in the treatment of the medical condition at issue and are knowledgeable about the recommended treatment through actual clinical experience;

(B) Hold a nonrestricted license issued by a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, government, or regulatory body;

(2) The independent review organization shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, a managed care entity, or a professional association of health care providers; and

(3) The independent review organization shall submit to the department the following information upon initial application for certification, and thereafter within 30 days of any change to any of the following information:

(A) The names of all owners of more than 5 percent of any stock or options, if a publicly held organization;

(B) The names of all holders of bonds or notes in excess of $100,000.00, if any;

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(D) The names of all directors, officers, and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care entity or organization, health care provider group, or board or committee.

(b) Neither the independent review organization nor any expert reviewer of the independent review organization shall have any material professional, familial, or financial conflict of interest with any of the following:

(1) A health benefit plan or payor being reviewed;

(2) Any officer, director, or management employee of a health benefit plan which is being reviewed;

(3) The physician, the physician's medical group, health care provider, or the independent practice association proposing a treatment under review;

(4) The institution at which a proposed treatment would be provided;

(5) The enrollee or the enrollee's representative; or

(6) The development or manufacture of the treatment proposed for the enrollee whose treatment is under review.

(c) As used in subsection (b) of this Code section, the term 'conflict of interest' shall not be interpreted to include a contract under which an academic medical center or other similar medical research center provides health care services to enrollees of a health benefit plan, except as subject to the requirement of paragraph (4) of subsection (b) of this Code section; affiliations which are limited to staff privileges at a health care facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center or other similar medical research center that is acting as an independent review organization under this chapter. An agreement to provide

independent review for an enrollee or payor shall not be a conflict of interest under subsection (b) of this Code section.

(d) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(e) The department shall provide upon the request of any interested person a copy of all nonproprietary information filed with it pursuant to this chapter. The department shall provide at least quarterly a current list of certified independent review organizations to all health benefit plan entities and to any interested persons.

33-20C-10.

For the purposes of this chapter, in making a determination as to whether a covered service and any limitation for such covered service is medically necessary and appropriate, the expert reviewer shall, in addition to the factors provided in Code Section 33-20C-11, consider whether such services or therapies are clinically appropriate, including, but not limited to, in terms of type, frequency, extent, site, duration, and effectiveness for the patient's illness, injury, or disease.

33-20C-11.

(a) For the purposes of this chapter, in making a determination as to whether a treatment is medically necessary and appropriate, the expert reviewer shall determine, based upon generally accepted medical practices in light of conditions at the time of such treatment, whether such treatment is:

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

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

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

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

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

(b) For the purposes of this chapter, in making a determination as to whether a treatment is experimental, the expert reviewer shall determine:

(1) Whether such treatment has been approved by the federal Food and Drug Administration; or

(2) Whether medical and scientific evidence demonstrates that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that the adverse risks of the proposed treatment will not be substantially increased over those of standard treatments.

For either determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision.

33-20C-12.

The department shall provide necessary rules and regulations for the implementation and operation of this chapter.″

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.