

The Senate Committee on Insurance and Labor offered the following substitute to SB 80:

A BILL TO BE ENTITLED
AN ACT

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 provide additional standards for utilization review; to provide for statutory construction; to
3 provide for applicability; to provide for definitions; to provide for a short title; to provide for
4 related matters; to provide for an effective date and applicability; to repeal conflicting laws;
5 and for other purposes.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

7 **SECTION 1.**

8 This Act shall be known and may be cited as the "Ensuring Transparency in Prior
9 Authorization Act."

10 **SECTION 2.**

11 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
12 revising Chapter 46, relating to certification of private review agents, as follows:

13

"ARTICLE 114 33-46-1.15 This chapter shall be construed liberally to promote consumer protection.16 33-46-2.17 This chapter applies to:18 (1) Private review agents;19 (2) All health insurers and stand-alone dental plans that provide accident and sickness
20 insurance products whether on an individual, group, or blanket basis as provided in this
21 title;22 (3) All administrators of such products licensed in accordance with Article 2 of
23 Chapter 23 of this title;24 (4) All pharmacy benefits managers;25 (5) All contracts entered into or renewed by the Department of Community Health with
26 a contracted entity to provide healthcare coverage or services pursuant to the state health
27 benefit plan;28 (6) All contracts entered into or renewed by the Department of Community Health and
29 care management organizations to provide or arrange for healthcare coverage or services
30 on a prepaid, capitated basis to members; and31 (7) All other entities and contracts as described and applicable herein.32 ~~33-46-1.~~ 33-46-3.33 (a) The purpose of this chapter is to promote the delivery of quality ~~health care~~ healthcare
34 in Georgia. Furthermore, it is to foster the delivery of such care in a cost-effective manner
35 through greater coordination between ~~health care~~ healthcare providers, claims
36 administrators, ~~payors, insurers,~~ employers, patients, and private review agents; to improve

37 communication and knowledge of ~~health-care~~ healthcare benefits among all parties; to
38 protect patients, claims administrators, ~~payors~~, insurers, private review agents, employers,
39 and ~~health-care~~ healthcare providers by ensuring that utilization review activities are based
40 upon accepted standards of treatment and patient care; to ensure that such treatment is
41 accessible and done in a timely and effective manner; and to ensure that private review
42 agents maintain confidentiality of information obtained in the course of utilization review.

43 (b) In order to carry out the intent and purposes of this chapter, it is declared to be the
44 policy of this chapter to protect Georgia residents by imposing minimum standards on
45 private review agents who engage in utilization review with respect to ~~health-care~~
46 healthcare services provided in Georgia, such standards to include regulations concerning
47 certification of private review agents, disclosure of utilization review standards and appeal
48 procedures, minimum qualifications for utilization review personnel, minimum standards
49 governing accessibility of utilization review, and such other standards, requirements, and
50 rules or regulations promulgated by the Commissioner which are not inconsistent with the
51 foregoing. Notwithstanding the foregoing, it is neither the policy nor the intent of the
52 General Assembly to regulate the terms of self-insured employee welfare benefit plans as
53 defined in Section 31(I) of the Employee Retirement Income Security Act of 1974, as
54 amended, and therefore any regulations promulgated pursuant to this chapter shall relate
55 only to persons subject to this chapter.

56 ~~33-46-2~~. 33-46-4.

57 As used in this chapter, the term:

58 (1) 'Adverse determination' means a decision by a utilization review entity that the
59 healthcare services furnished or proposed to be furnished to a covered person are not
60 medically necessary or are experimental or investigational; and benefit coverage is
61 therefore denied, reduced, or terminated. Such term shall not mean a decision to deny.

62 reduce, or terminate services that are not covered for reasons other than their medical
63 necessity or experimental or investigational nature.

64 (2) 'Authorization' means a determination by a utilization review entity that a healthcare
65 service has been reviewed and, based on the information provided, satisfies the utilization
66 review entity's requirements for medical necessity and appropriateness.

67 (3) 'Care management organization' means an entity that is organized for the purpose of
68 providing or arranging healthcare, which has been granted a certificate of authority by the
69 Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21
70 of this title and which has entered into a contract with the Department of Community
71 Health to provide or arrange for healthcare services on a prepaid, capitated basis to
72 members.

73 ~~(4)~~(4) 'Certificate' means a certificate of registration granted by the Commissioner to a
74 private review agent.

75 ~~(2)~~(5) 'Claim administrator' means any entity that reviews and determines whether to pay
76 claims to enrollees of ~~health care~~ healthcare providers on behalf of the ~~health benefit~~
77 healthcare plan. Such payment determinations are made on the basis of contract
78 provisions including medical necessity and other factors. Claim administrators may be
79 ~~payors~~ insurers or their designated review organization, self-insured employers,
80 management firms, third-party administrators, or other private contractors.

81 (6) 'Clinical criteria' means the written policies, written screening procedures, drug
82 formularies or lists of covered drugs, determination rules, determination abstracts, clinical
83 protocols, practice guidelines, medical protocols, and any other criteria or rationale used
84 by the utilization review entity to determine the necessity and appropriateness of
85 healthcare services.

86 ~~(3) "Commissioner" means the Commissioner of Insurance.~~

87 (7) 'Covered person' means an individual, including, but not limited to, any subscriber,
88 enrollee, member, beneficiary, participant, or his or her dependent, eligible to receive

89 healthcare benefits by a health insurer pursuant to a healthcare plan or other health
90 insurance coverage.

91 (8) 'Emergency healthcare services' means healthcare services rendered after the recent
92 onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms
93 of sufficient severity, including, but not limited to, severe pain, that would lead a prudent
94 layperson possessing an average knowledge of medicine and health to believe that his or
95 her condition, sickness, or injury is of such a nature that failure to obtain immediate
96 medical care could result in:

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

98 (B) Serious impairment to bodily functions; or

99 (C) Serious dysfunction of any bodily organ or part.

100 ~~(4) 'Enrollee' means the individual who has elected to contract for or participate in a~~
101 ~~health benefit plan for himself or himself and his eligible dependents.~~

102 (9) 'Facility' means a hospital, ambulatory surgical center, birthing center, diagnostic and
103 treatment center, hospice, or similar institution. Such term shall not mean a healthcare
104 provider's office.

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

107 ~~(6)~~(10) 'Healthcare Healthcare advisor' means a healthcare healthcare provider licensed
108 in a state representing the claim administrator or private review agent who provides
109 advice on issues of medical necessity or other patient care issues.

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

114 (12) 'Healthcare plan' means any hospital or medical insurance policy or certificate,
115 healthcare plan contract or certificate, qualified higher deductible health plan, stand-alone

116 dental plan, health maintenance organization or other managed care subscriber contract,
117 the state health benefit plan, or any plan entered into by a care management organization
118 as permitted by the Department of Community Health for the delivery of healthcare
119 services.

120 ~~(7)~~(13) 'Health care Healthcare provider' means any person, corporation, facility, or
121 institution licensed by this state or any other state to provide or otherwise lawfully
122 providing ~~health care~~ healthcare services, including but not limited to a doctor of
123 medicine, doctor of osteopathy, hospital or other ~~health care~~ healthcare facility, dentist,
124 nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist,
125 professional counselor, pharmacist, chiropractor, marriage and family therapist, or social
126 worker.

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

132 (15) 'Indication' means the basis for initiating treatment for a disease or a diagnostic test.

133 (16) 'Medical necessity' or 'medically necessary' means healthcare services that a prudent
134 physician or other healthcare provider would provide to a patient for the purpose of
135 preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a
136 manner that is:

137 (A) In accordance with generally accepted standards of medical or other healthcare
138 practice;

139 (B) Clinically appropriate in terms of type, frequency, extent, site, and duration;

140 (C) Not primarily for the economic benefit of the health insurer or for the convenience
141 of the patient, treating physician, or other healthcare provider; and

142 (D) Not primarily custodial care, unless custodial care is a covered service or benefit
143 under the covered person's healthcare plan.

144 (17) 'Member' means a Medicaid or Peachcare for Kids recipient who is currently
145 enrolled in a care management organization plan.

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

152 (18) 'Pharmacy benefits manager' means a person, business entity, or other entity that
153 performs pharmacy benefits management. Such term includes a person or entity acting
154 for a pharmacy benefits manager in a contractual or employment relationship in the
155 performance of pharmacy benefits management for a healthcare plan. Such term shall
156 not include services provided by pharmacies operating under a hospital pharmacy license.
157 Such term shall not include health systems while providing pharmacy services for their
158 patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for
159 outpatient procedures. Such term shall not include services provided by pharmacies
160 affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model
161 health maintenance organization with an exclusive medical group contract and which
162 operates its own pharmacies which are licensed under Code Section 26-4-110.

163 (19) 'Prior authorization' means the process by which a utilization review entity
164 determines the medical necessity or medical appropriateness of otherwise covered
165 healthcare services prior to or concurrent with the rendering of such services. Such term
166 shall include any health insurer's or utilization review entity's requirement that a covered
167 person or healthcare provider notify the health insurer or utilization review entity prior
168 to providing a healthcare service.

169 ~~(9)~~(20) 'Private review agent' means any person or entity which performs utilization
 170 review for:

171 (A) An employer with employees who are treated by a ~~health care~~ healthcare provider
 172 in this state;

173 (B) ~~A payor~~ An insurer; or

174 (C) A claim administrator.

175 ~~(10) 'Reasonable target review period' means the assignment of a proposed number of~~
 176 ~~days for review for the proposed health care services based upon reasonable length of~~
 177 ~~stay standards such as the Professional Activities Study of the Commission on the~~
 178 ~~Professional and Hospital Activities or other Georgia state-specific length of stay data.~~

179 (21) 'State health benefit plan' means the health insurance plan or plans established
 180 pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 and Article 1 of Chapter 18 of
 181 Title 45 for state and public employees, dependents, and retirees.

182 (22) 'Urgent healthcare service' means a healthcare service with respect to which the
 183 application of the time periods for making a nonexpedited prior authorization, which, in
 184 the opinion of a physician or other healthcare provider with knowledge of the covered
 185 person's medical condition:

186 (A) Could seriously jeopardize the life or health of the covered person or the ability of
 187 such person to regain maximum function; or

188 (B) Could subject the covered person to severe pain that cannot be adequately managed
 189 without the care or treatment that is the subject of the utilization review.

190 Such term shall include services provided for the treatment of substance use disorders
 191 which otherwise qualify as an urgent healthcare service.

192 ~~(11)~~(23) 'Utilization review' means a system for reviewing the appropriate and efficient
 193 allocation or charges of hospital, outpatient, medical, or other ~~health care~~ healthcare
 194 services given or proposed to be given to a patient or group of patients for the purpose
 195 of advising the claim administrator who determines whether such services or the charges

196 therefor should be covered, provided, or reimbursed by ~~a payor~~ an insurer according to
 197 the benefits plan. Utilization review shall not include the review or adjustment of claims
 198 or the payment of benefits arising under liability, workers' compensation, or malpractice
 199 insurance policies as defined in Code Section 33-7-3.

200 (24) 'Utilization review entity' means an individual, insurer, or other entity that performs
 201 prior authorization for one or more of the following entities:

202 (A) An insurer that writes health insurance policies;

203 (B) A preferred provider organization or health maintenance organization; or

204 (C) Any other individual or entity that provides, offers to provide, or administers
 205 hospital, outpatient, medical, behavioral health, prescription drug, or other health
 206 benefits to a person treated by a healthcare provider in this state under a health
 207 insurance policy, plan, or contract.

208 ~~(12)~~(25) 'Utilization review plan' means a reasonable description of the standards,
 209 criteria, policies, procedures, reasonable target review periods, and reconsideration and
 210 appeal mechanisms governing utilization review activities performed by a private review
 211 agent.

212 ~~33-46-3.~~ 33-46-5.

213 (a) A private review agent may not conduct utilization review of ~~health care~~ healthcare
 214 provided in this state unless the Commissioner has granted the private review agent a
 215 certificate pursuant to this chapter. No individual conducting utilization review shall
 216 require certification if such utilization review is performed within the scope of such
 217 person's employment with an entity already certified pursuant to this Code section.

218 (b) The Commissioner shall issue a certificate to an applicant that has met all the
 219 requirements of this chapter and all applicable regulations of the Commissioner.

220 (c) A certificate issued under this chapter is not transferable without the prior approval of
 221 the Commissioner.

222 ~~33-46-4.~~ 33-46-6.

223 As a condition of certification or renewal thereof, a private review agent shall be required
224 to maintain compliance with the following:

225 (1) Where not otherwise addressed in this chapter or department regulations, ~~The~~ the
226 medical protocols including reconsideration and appeal processes as well as other
227 relevant medical issues used in the private review program shall be established with input
228 from ~~health care~~ healthcare providers who are from a major area of specialty and certified
229 by the boards of the American medical specialties selected by a private review agency
230 and documentation of such protocols shall be made available upon request of ~~health care~~
231 healthcare providers; or, ~~where not so addressed,~~ protocols, including reconsideration and
232 appeal processes as well as other relevant ~~health care~~ healthcare issues used in the private
233 review program, shall be established based on input from persons who are licensed in the
234 appropriate ~~health care~~ healthcare provider's specialty recognized by a licensure agency
235 of such a ~~health care~~ healthcare provider;

236 (2) All preadmission review programs shall provide for immediate hospitalization of any
237 patient for whom the treating ~~health care~~ healthcare provider determines the admission
238 to be of an emergency nature, so long as medical necessity is subsequently documented;

239 ~~(3) In the absence of any contractual agreement between the health care provider and the~~
240 ~~payor, the responsibility for obtaining precertification as well as concurrent review~~
241 ~~required by the payor shall be the responsibility of the enrollee;~~

242 ~~(4)~~(3) In cases where a private review agent is responsible for utilization review for a
243 ~~payor~~ an insurer or claim administrator, the utilization review agent should respond
244 promptly and efficiently in accordance with this chapter to all requests including
245 concurrent review in a timely method, and a method for an expedited authorization
246 process shall be available in the interest of efficient patient care;

247 ~~(5) In any instances where the utilization review agent is questioning the medical~~
248 ~~necessity or appropriateness of care, the attending health care provider shall be able to~~

249 ~~discuss the plan of treatment with an identified health care provider trained in a related~~
250 ~~specialty and no adverse determination shall be made by the utilization review agent until~~
251 ~~an effort has been made to discuss the patient's care with the patient's attending provider~~
252 ~~during normal working hours. In the event of an adverse determination, notice to the~~
253 ~~provider and patient will specify the reasons for the review determination;~~

254 ~~(6) To the extent that utilization review programs are administered according to~~
255 ~~recognized standards and procedures, efficiently with minimal disruption to the provision~~
256 ~~of medical care, additional payment to providers should not be necessary;~~

257 ~~(7)~~(4) A private review agent shall assign a reasonable target review period in
258 accordance with this chapter for each admission promptly upon notification by the ~~health~~
259 ~~care~~ healthcare provider. Once a target length of stay has been agreed upon with the
260 ~~health care~~ healthcare provider, the utilization review agent will not attempt to contact
261 the ~~health care~~ healthcare provider or patient for further information until the end of that
262 target review period except for discharge planning purposes or in response to a contact
263 by a patient or ~~health care~~ healthcare provider. The provider or the ~~health care~~ healthcare
264 facility will be responsible for alerting the utilization review agent in the event of a
265 change in proposed treatment. At the end of the target period, the private review agent
266 will review the care for a continued stay;

267 ~~(8)~~(5) A private review agent shall not enter into any incentive payment provision
268 contained in a contract or agreement with a ~~payor~~ an insurer which is based on reduction
269 of services or the charges thereof, reduction of length of stay, or utilization of alternative
270 treatment settings; and

271 ~~(9)~~(6) Any ~~health care~~ healthcare provider may designate one or more individuals to be
272 contacted by the private review agent for information or data. In the event of any such
273 designation, the private review agent shall not contact other employees or personnel of
274 the ~~health care~~ healthcare provider except with prior consent to the ~~health care~~ healthcare

275 provider. An alternate will be available during normal business hours if the designated
276 individual is absent or unavailable.

277 ~~33-46-5.~~ 33-46-7.

278 (a) An applicant for a certificate shall submit an application on a form prescribed by the
279 Commissioner and pay an application fee and a certificate fee as provided in Code
280 Section 33-8-1. The application shall be signed and verified by the applicant.

281 (b) In conjunction with the application, the private review agent shall submit such
282 information that the Commissioner requires, including but not limited to:

283 (1) A utilization review plan;

284 (2) The type and qualifications of the personnel either employed or under contract to
285 perform the utilization review; and

286 (3) A copy of the materials designed to inform applicable patients and ~~health care~~
287 healthcare providers of the requirements of the utilization review plan.

288 The information provided must demonstrate to the satisfaction of the Commissioner that
289 the private review agent will comply with the requirements of this chapter.

290 ~~33-46-6.~~ 33-46-8.

291 (a) A certificate shall expire on the second anniversary of its effective date unless the
292 certificate is renewed for a two-year term as provided in this Code section.

293 (b) Before the certificate expires but no sooner than 90 days prior to such expiration, a
294 certificate may be renewed for an additional two-year term if the applicant:

295 (1) Otherwise is entitled to the certificate;

296 (2) Pays to the Commissioner the renewal fee as provided in Code Section 33-8-1;

297 (3) Submits to the Commissioner:

298 (A) A renewal application on the form that the Commissioner requires; and

299 (B) Satisfactory evidence of compliance with any requirements established by the
300 Commissioner for certificate renewal; and

301 (4)(A) Establishes and maintains a complaint system which has been approved by the
302 Commissioner and which provides reasonable procedures for the resolution of written
303 complaints initiated by ~~enrollees~~ covered persons or ~~health-care~~ healthcare providers
304 concerning utilization review;

305 (B) Maintains records of such written complaints for five years from the time the
306 complaints are filed and submits to the Commissioner a summary report at such times
307 and in such format as the Commissioner may require; and

308 (C) Permits the Commissioner to examine the complaints at any time.

309 ~~33-46-7.~~ 33-46-9.

310 Private review agents shall be subject to the jurisdiction of the Commissioner in all matters
311 regulated by this chapter and the Commissioner shall have such powers and authority with
312 regard to private review agents as provided in Code Sections 33-2-9 through 33-2-28 with
313 regard to insurers.

314 ~~33-46-8.~~ 33-46-10.

315 Private review agents shall be subject to the provisions of Chapter 39 of this title.

316 ~~33-46-9.~~ 33-46-11.

317 The Commissioner shall periodically, not less than once a year, provide a list of private
318 review agents issued certificates and the renewal date for those certificates to all hospitals
319 and to any other individual or organization requesting such list.

320 ~~33-46-10:~~ 33-46-12.

321 The Commissioner shall establish such reporting requirements upon private review agents
322 as are necessary to determine if the utilization review programs are in compliance with the
323 provisions of this chapter and applicable rules and regulations.

324 ~~33-46-11:~~ 33-46-13.

325 The Commissioner shall adopt rules and regulations to implement the provisions of this
326 chapter.

327

328 ~~33-46-12:~~ 33-46-14.

329 No certificate is required for utilization review by any Georgia licensed pharmacist or
330 pharmacy while engaged in the practice of pharmacy, including but not limited to review
331 of the dispensing of drugs, participation in drug utilization review, and monitoring patient
332 drug therapy.

333 ~~33-46-13:~~ 33-46-15.

334 (a) This chapter shall not apply to any contract with the federal government for utilization
335 and review of patients eligible for hospital services under Title XVIII or XIX of the Social
336 Security Act.

337 (b) This chapter shall not apply to any private review agent when such private review
338 agent is working under contract, or an extension or renewal thereof, with a licensed insurer
339 operating under an agreement, providing administrative services pursuant to the provisions
340 of subsection (b) of Code Section 33-20-17 to a ~~health-care~~ healthcare benefit plan
341 negotiated through collective bargaining as that term is defined in the federal National
342 Labor Relations Act, as amended, if the original agreement was executed and in effect prior
343 to January 1, 1990.

344 (c) This chapter shall not apply to audits of the medical record for the purposes of
345 verifying that ~~health care~~ healthcare services were ordered and delivered.

346 ~~33-46-14.~~ 33-46-16.

347 The Commissioner shall issue an annual report to the Governor and the General Assembly
348 concerning the conduct of utilization review in this state. Such report shall include a
349 description of utilization review programs and the services they provide, an analysis of
350 complaints filed against private review agents by patients or providers, and an evaluation
351 of the impact of utilization review programs on patient access to care. The Commissioner
352 shall not be required to distribute copies of the annual report to ~~the members~~ legislators of
353 in the General Assembly but shall notify ~~the members~~ such legislators of the availability
354 of the report in the manner which he or she deems to be most effective and efficient.

355

ARTICLE 2

356 33-46-20.

357 (a) An insurer shall make any current prior authorization requirements and restrictions
358 readily accessible on its website to healthcare providers. Clinical criteria on which an
359 adverse determination is based shall be provided to the healthcare provider at the time of
360 the notification.

361 (b) If an insurer intends either to implement a new prior authorization requirement or
362 restriction or amend an existing requirement or restriction, such insurer shall ensure that
363 the new or amended requirement or restriction is not implemented unless such insurer's
364 website has been updated to reflect such addition or change.

365 (c) An insurer using prior authorization shall make statistics available regarding prior
366 authorization approvals and denials on its website in a readily accessible format. Such
367 statistics shall include categories for:

- 368 (1) Physician or other provider speciality;
369 (2) Medication or diagnostic tests and procedures;
370 (3) Indication offered;
371 (4) Approved or denied on initial request;
372 (5) Reason for denial;
373 (6) Whether appealed;
374 (7) Whether approved or denied on appeal; and
375 (8) Time between submission and response.

376 33-46-21.

377 An insurer shall ensure that all adverse determinations are made by a physician, dentist,
378 pharmacist, or other appropriately credentialed healthcare provider who shall possess a
379 current and valid nonrestricted license or maintain other appropriate legal authorization to
380 provide the healthcare services reviewed and who shall:

- 381 (1) Practice in the same specialty as the physician or other healthcare provider who
382 typically manages the condition or disease or regularly provides the healthcare service
383 involved in the request; or
384 (2) Have practical experience treating patients with the condition or disease for which
385 the healthcare service is being requested.

386 33-46-22.

387 If a utilization review entity questions the medical necessity of a healthcare service, such
388 entity shall notify the covered person's physician or other healthcare provider familiar with
389 the case that medical necessity is being questioned. At least 72 hours before the final
390 decision is made with regard to the medical necessity of such healthcare service, the
391 covered person's physician or other healthcare provider shall have the opportunity to
392 discuss such necessity on the telephone or through synchronous digital text or voice

393 messaging or similar technology with the physician or other healthcare provider who will
394 be responsible for making the final decision with regard to the medical necessity of the
395 healthcare service in question.

396 33-46-23.

397 A utilization review entity shall ensure that all appeals are reviewed by a physician, dentist,
398 pharmacist, or other appropriately credentialed healthcare provider who shall possess a
399 current and valid nonrestricted license or maintain other appropriate legal authorization to
400 provide the healthcare services reviewed and who shall:

401 (1) Practice in the same specialty as the physician or other healthcare provider who
402 typically manages the condition or disease or regularly provides the healthcare service
403 involved in the request;

404 (2) Have practical experience treating patients with the condition or disease for which
405 the healthcare service is being requested;

406 (3) Not be employed by a utilization review entity or be under contract with a utilization
407 review entity other than to participate in one or more of the utilization review entity's
408 healthcare provider networks or to perform reviews of appeals, or otherwise have any
409 financial interest in the outcome of the appeal;

410 (4) Not have been directly involved in making the adverse determination; and

411 (5) Consider all known clinical aspects of the healthcare service under review, including,
412 but not limited to, a review of all pertinent medical or other records provided to the
413 utilization review entity by the covered person's healthcare provider, any relevant records
414 provided to the utilization review entity by a facility, and any medical or other literature
415 provided to the utilization review entity by the healthcare provider.

416 33-46-24.

417 If a utilization review entity requires prior authorization of a healthcare service, the
418 utilization review entity shall notify the covered person and such person's healthcare
419 provider of its prior authorization or adverse determination within seven calendar days of
420 obtaining all necessary information to make such authorization or adverse determination.
421 For purposes of this Code section, 'necessary information' includes the results of any
422 face-to-face clinical evaluation or second opinion that may be required.

423 33-46-25.

424 A utilization review entity shall render a prior authorization or adverse determination
425 concerning urgent healthcare services and notify the covered person and such person's
426 healthcare provider of that prior authorization or adverse determination no later than 72
427 hours after receiving all information needed to complete the review of the requested
428 healthcare services.

429 33-46-26.

430 An insurer cannot require prior authorization for emergency prehospital ambulance
431 transportation or for the provision of emergency healthcare services.

432 33-46-27.

433 If initial healthcare services are performed within 45 business days of approval of prior
434 authorization, the insurer shall not revoke, limit, condition, or restrict such authorization,
435 unless such authorization is for a Schedule II controlled substance.

436 33-46-28.

437 A covered person's physician or dentist may change the dosage of a prescription drug for
438 such covered person and such change shall not affect a utilization review entity's decision.

439 33-46-29.

440 Prior authorization shall not be required for unanticipated covered healthcare services
441 which are incidental to the primary covered healthcare services and determined by the
442 covered person's physician or dentist to be medically necessary.

443 33-46-30.

444 If an insurer requires a prior authorization for a healthcare service for the treatment of a
445 chronic or long-term care condition, the prior authorization shall remain valid for six
446 months during which time the insurer shall not require the covered person to obtain a prior
447 authorization again for such healthcare service.

448 33-46-31.

449 Prior authorization of a covered healthcare service shall be a guarantee of payment to the
450 provider if such services are performed unless there is a billing error, fraud, material
451 misrepresentation, or loss of coverage.

452 33-46-32.

453 (a) Upon receipt of information documenting a prior authorization from the covered person
454 or from such person's healthcare provider, a utilization review entity for at least the
455 initial 30 days of such person's new coverage shall honor a prior authorization for a covered
456 healthcare service granted to him or her from a previous utilization review entity even if
457 approval criteria or products of a healthcare plan have changed or such person is covered
458 under a new healthcare plan, so long as the former criteria, products, or plans are not
459 binding upon a new insurer.

460 (b) During the time period described in subsection (a) of this Code section, a utilization
461 review entity may perform its own review to grant a prior authorization.

462 (c) If there is a change in coverage of, or approval criteria for, a previously authorized
463 healthcare service, the change in coverage or approval criteria shall not affect a covered
464 person who received prior authorization before the effective date of such change for the
465 remainder of the covered person's plan year so long as such covered person remains
466 covered by the same insurer.

467 (d) A utilization review entity shall continue to honor a prior authorization it has granted
468 to a covered person in accordance with this Code section.

469 33-46-33.

470 Each failure by a utilization review entity to comply with the deadlines or other
471 requirements specified in this chapter shall result in the automatic authorization of
472 healthcare services under review by such utilization review entity if such noncompliance
473 is related to such services.

474 33-46-34.

475 With regard to the provision of healthcare services, each contract entered into or renewed
476 by a managed care organization, each contract entered into or renewed by the Department
477 of Community Health with a care management organization, and each contract entered into
478 by such board with a contracted entity pursuant to the state health benefit plan shall comply
479 with this chapter.

480 33-46-35.

481 The Commissioner shall not have the authority to approve, disapprove, or modify any plan
482 offered by a care management organization or any contract between a care management
483 organization and the Department of Community Health. Compliance with this chapter by
484 care management organizations shall be enforced by the Department of Community Health.

485 33-46-36.

486 The Commissioner shall not have the authority to approve, disapprove, or modify the state
487 health benefit plan or the contracts entered into by the Department of Community Health
488 with a contracted entity to provide healthcare coverage or services pursuant to the state
489 health benefit plan. Compliance with this chapter regarding the state health benefit plan
490 shall be enforced by the Department of Community Health.

491 33-46-37.

492 Nothing in this chapter shall be construed as reducing the authority of the commissioner
493 of community health."

494 **SECTION 3.**

495 This Act shall become effective on January 1, 2022, and shall apply to all policies or
496 contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

497 **SECTION 4.**

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