

Senate Bill 602

By: Senators Parkes of the 7th, Mangham of the 55th, James of the 28th, Kemp of the 38th  
and Harrell of the 40th

A BILL TO BE ENTITLED  
AN ACT

1 To amend Article 2 of Chapter 46 of Title 33 of the Official Code of Georgia Annotated,  
2 relating to prior authorization, so as to reform prior authorization and utilization review  
3 requirements for healthcare plans; to provide for certain information to be provided to  
4 healthcare providers at the time of notification of an adverse determination; to provide for  
5 aggregate statistics of certain data; to provide for the Commissioner of Insurance to  
6 summarize and report certain data; to provide for specific criteria as part of an insurer's  
7 program not requiring prior authorizations under certain conditions; to provide for  
8 definitions; to limit documentation for utilization review; to provide for technology  
9 requirements for utilization review; to provide for prior authorizations to remain valid; to  
10 provide for retroactive authorizations; to exempt certain healthcare services from prior  
11 authorization; to revise prior authorization time responses; to provide for automatic  
12 authorization; to provide for the chapter construction; to provide for related matters; to  
13 provide for an effective date and applicability; to repeal conflicting laws; and for other  
14 purposes.

15 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

16

**SECTION 1.**

17 Article 2 of Chapter 46 of Title 33 of the Official Code of Georgia Annotated, relating to  
 18 prior authorizations, is amended by revising Code Section 33-46-20, relating to prior  
 19 authorization requirements posted on website and statistical reporting, as follows:

20 "33-46-20.

21 (a) An insurer shall make any current prior authorization requirements readily accessible  
 22 on its website to healthcare providers. ~~Clinical criteria on which an adverse determination~~  
 23 ~~is based shall be provided to the healthcare provider at~~ At the time of the notification of an  
 24 adverse determination, the healthcare provider shall be provided:

25 (1) The clinical criteria on which the adverse determination is based;

26 (2) Detailed reasoning for such determination;

27 (3) The national provider identifier, credentials, specialty, and board certification of the  
 28 reviewing physician; and

29 (4) The healthcare provider's rights and procedures for appeal.

30 (b) If an insurer intends either to implement a new prior authorization requirement or to  
 31 amend an existing requirement, such insurer shall ensure that the new or amended  
 32 requirement is not implemented unless such insurer's website has been updated to reflect  
 33 such addition or change. An insurer shall not retroactively deny coverage for a healthcare  
 34 service that received prior authorization.

35 (c) An insurer using prior authorization shall make aggregate statistics available per such  
 36 insurer and per its plans regarding prior authorization approvals and denials on its website  
 37 in a readily accessible format. The Commissioner shall determine the statistics required  
 38 in order to comply with this Code section in accordance with applicable state and federal  
 39 privacy laws. Such statistics shall include, but not be limited to, the following:

40 ~~(1) Approved or denied on~~ The total number of initial requests for prior authorization,  
 41 whether each initial request was approved or denied, and the approval and denial rates;

42 (2) Reason for denial;

- 43 (3) Whether appealed and the appeal rates;
- 44 (4) Whether approved or denied on appeal and the approval and denial rates; and
- 45 (5) Time between submission and response and the average response times;
- 46 (6) Whether the prior authorization, adverse determination, or appeal procedure was
- 47 compliant with time requirements of this chapter; and
- 48 (7) Whether the prior authorization, adverse determination, or appeal procedure was
- 49 compliant with procedural requirements of this chapter.
- 50 (d) The Commissioner shall include a summary of the prior authorization data required
- 51 under this Code section in the annual report required under Code Section 33-49-16."

52

## SECTION 2.

53 Said article is further amended by revising subsection (b) of Code Section 33-46-20.1,

54 relating to program of selective application of reductions in prior authorization requirements,

55 as follows:

56 "(b) Criteria for participation by healthcare providers and the healthcare services included

57 in the program shall be at the discretion of the insurer; provided, however, that ~~such~~ each

58 insurer shall include in the program a provision under which such insurer shall not require

59 prior authorization from a healthcare provider for a specific healthcare service if, in the

60 prior 12 month period, the insurer has approved not less than 80 percent of such healthcare

61 provider's prior authorization requests for such healthcare service. Such exemption shall

62 remain in effect for not less than 12 months, unless the insurer determines there has been

63 fraud or material misrepresentation. Each insurer shall submit to the department a filing

64 concerning such program. Such filing shall include a full narrative description of the

65 program, the criteria for participation in the program, a list of the procedures and services

66 subject to the program, the number of healthcare providers participating in the program,

67 and any other information deemed necessary by the department."

68

**SECTION 3.**

69 Said article is further amended by revising subsection (d) and adding new subsections to  
70 Code Section 33-46-21, relating to insurer responsibility for compliance, periodic reviews,  
71 and evaluation of adverse determinations, to read as follows:

72 "(d) As used in this subsection, the term 'qualified healthcare provider' shall have the same  
73 meaning as set forth in Code Section 33-46-22. Qualified healthcare professionals  
74 providers shall administer the utilization review program and oversee utilization review  
75 decisions. An initial screening of prior authorization requests may be completed without  
76 providing the treating provider or other qualified healthcare professional provider with the  
77 opportunity to speak with a clinical peer of the private review agent or utilization review  
78 entity. Such an opportunity shall be provided, however, before an appeal. If a private  
79 review agent or utilization review entity questions the medical necessity of a healthcare  
80 service, such agent or entity shall notify the covered person's treating provider, or such  
81 provider's appropriately qualified designee familiar with the patient's case, that medical  
82 necessity is being questioned in accordance with the provisions of paragraph (5) of  
83 subsection (a) of Code Section 33-46-6."

84 "(f) Any documentation requests under the utilization review program shall be limited to  
85 information reasonably necessary to establish medical necessity. Duplicative and irrelevant  
86 documentation shall not be required.

87 (g) Any utilization review program shall accept and respond to prior authorization requests  
88 through secured electronic transmission standards for pharmacy transactions. Technology  
89 not integrated into a healthcare provider's electronic health record shall not be deemed  
90 compliant."

91

**SECTION 4.**

92 Said article is further amended by revising Code Section 33-46-22, relating to review of  
93 appeals by appropriate healthcare provider, as follows:

94 "33-46-22.

95 A private review agent or utilization review entity shall ensure that all adverse  
 96 determinations are made and all appeals of adverse determinations are reviewed by an  
 97 appropriate a qualified healthcare provider provider. As used in this Code section, the term  
 98 'qualified healthcare provider' means a licensed physician who shall:

99 (1) Possess a current and valid nonrestricted license or maintain other appropriate legal  
 100 authorization;

101 (2) Be currently in active practice in the same or similar specialty and who typically  
 102 manages the medical condition or disease;

103 (3) Be knowledgeable of, and have experience providing, the healthcare service under  
 104 appeal;

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

106 (5) Consider all known clinical aspects of the healthcare service under review, including,  
 107 but not limited to, a review of all pertinent medical or other records provided to the  
 108 private review agent or utilization review entity by the covered person's healthcare  
 109 provider, any relevant records provided to such agent or entity by a facility, and any  
 110 medical or other literature provided to such agent or entity by the healthcare provider."

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112

### SECTION 5.

113 Said article is further amended by revising Code Section 33-46-23, relating to restrictions on  
 114 authorizations when service timely rendered, as follows:

115 "33-46-23.

116 (a) If ~~initial~~ healthcare services are performed within ~~45 business days~~ one year of  
 117 approval of prior authorization, the insurer shall not revoke, limit, condition, or restrict  
 118 such authorization, unless such prior authorization is for a Schedule II controlled substance  
 119 or there is a billing error, fraud, material misrepresentation, or loss of coverage.

120 (b) Except for ongoing medication therapy of chronic conditions as provided for in Code  
121 Section 33-46-23.1, a prior authorization of a healthcare service shall remain valid for the  
122 lesser of one year from the date the healthcare provider receives prior authorization, the  
123 duration of the treatment of the condition of the covered person, or until the last day of  
124 coverage under the covered person's healthcare plan, unless there is fraud or material  
125 misrepresentation."

126 **SECTION 6.**

127 Said article is further amended by adding a new Code section to read as follows:

128 "33-46-23.2.

129 (a) As used in this Code section, the term 'retroactive authorization' means any written or  
130 oral determination made by a claim administrator or an insurer, or any agent thereof, after  
131 a covered person's receipt of a healthcare service that such service is a covered benefit  
132 under the applicable plan and that any requirement of medical necessity or other  
133 requirements imposed by such plan as prerequisites for payment for such service are  
134 satisfied. The term 'agent' as used in this subsection shall not include an agent or agency  
135 as defined in Code Section 33-23-1.

136 (b) A healthcare provider may submit a request for a retroactive authorization for a  
137 healthcare service within ten days of rendering such service.

138 (c) A claim for coverage of a healthcare service shall not be denied solely for a healthcare  
139 provider's failure to obtain prior authorization."

140 **SECTION 7.**

141 Said article is further amended by revising Code Section 23-46-24, relating to medically  
142 necessary unanticipated emergency or urgent healthcare services, as follows:

143 "33-46-24.

144 (a) Prior authorization shall not be required for unanticipated emergency healthcare  
145 services, urgent healthcare services, or covered healthcare services which are incidental  
146 to the primary covered healthcare service and determined by the covered person's physician  
147 or dentist to be medically necessary.

148 (b) Prior authorization shall not be required for medications for opioid use disorder for a  
149 covered person under a healthcare plan."

150 **SECTION 8.**

151 Said article is further amended by revising Code Section 33-46-26, relating to timely  
152 notification of prior authorization or adverse determination, as follows:

153 "33-46-26.

154 Effective January 1, 2022, until December 31, 2022, if an insurer requires prior  
155 authorization of a healthcare service, a private review agent or utilization review entity  
156 shall notify the covered person's healthcare provider, or such provider's appropriately  
157 qualified designee, of any prior authorization or adverse determination within 15 calendar  
158 days of obtaining all necessary information to make such authorization or adverse  
159 determination. Effective January 1, 2023, if an insurer requires prior authorization of a  
160 healthcare service, a private review agent or utilization review entity shall notify the  
161 covered person's healthcare provider, or such provider's appropriately qualified designee,  
162 of any prior authorization or adverse determination within ~~7 calendar days~~ 48 hours of  
163 obtaining all necessary information to make such authorization or adverse determination."

164 **SECTION 9.**

165 Said article is further amended by revising Code Section 33-46-27, relating to notification  
166 time for prior authorization or adverse determination, as follows:

167 "33-46-27.

168 A private review agent or utilization review entity shall render a prior authorization or  
169 adverse determination concerning urgent healthcare services and notify such person's  
170 healthcare provider, or such provider's appropriately qualified designee, of that prior  
171 authorization or adverse determination no later than ~~72 hours~~ 24 hours after receiving all  
172 information needed to complete the review of the requested healthcare services."

173 **SECTION 10.**

174 Said article is further amended by revising subsection (a) of Code Section 33-46-28, relating  
175 to honoring prior authorizations, as follows:

176 "(a) Upon receipt of information documenting a prior authorization from a covered person  
177 or from a covered person's healthcare provider, a private review agent or utilization review  
178 entity, for at least the initial ~~30~~ 90 days of such person's new coverage, shall honor a prior  
179 authorization for a covered healthcare service granted to him or her from a previous private  
180 review agent or utilization review entity even if approval criteria or products of a  
181 healthcare plan have changed or such person is covered under a new healthcare plan, so  
182 long as the former criteria, products, or plans are not binding upon a new insurer."

183 **SECTION 11.**

184 Said article is further amended by revising Code Section 33-46-29, relating to noncompliance  
185 resulting in automatic authorization, as follows:

186 "33-46-29.

187 Each violation by a private review agent or utilization review entity of deadline or other  
188 requirements specified in this chapter shall result in the automatic authorization of  
189 healthcare services under review by such private review agent or utilization review entity  
190 if such noncompliance is related to such services. ~~Notwithstanding the foregoing,~~  
191 ~~noncompliance based on a de minimis violation that does not cause, or is not likely to~~

192 ~~cause, prejudice or harm to the covered person shall not result in the automatic~~  
193 ~~authorization of such healthcare services, so long as the insurer demonstrates that the~~  
194 ~~violation occurred due to good cause or due to matters beyond the control of the insurer~~  
195 ~~and that such violation occurred in the context of an ongoing good faith exchange of~~  
196 ~~information between the insurer and the covered person, or, if applicable, the covered~~  
197 ~~person's healthcare provider or authorized representative."~~

198 **SECTION 12.**

199 Said article is further amended by revising Code Section 33-46-32, relating to  
200 Commissioner's authority not reduced, as follows:

201 "33-46-32.

202 Nothing in this chapter shall be construed as:

203 (1) Mandating coverage of any specific healthcare service;

204 (2) Granting the Commissioner authority to determine covered benefits;

205 (3) Altering the medical necessity standards of a healthcare plan, except as expressly  
206 provided;

207 (4) Reducing the Commissioner's authority, including, but not limited to, conducting  
208 market conduct examinations and imposing monetary penalties for violations of any  
209 provisions of this title; or

210 (5) Reducing ~~reducing~~ the authority of the commissioner of community health."

211 **SECTION 13.**

212 This Act shall become effective on January 1, 2027, and shall apply to all policies or  
213 contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

214 **SECTION 14.**

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