MAG Fact Sheet

Georgia Health Insurance Law FAQ

The Medical Association of Georgia (MAG) prepared the following summary as a resource for its members. This summary addresses key state insurance laws, and it applies to any fully-insured managed care plan. This is not a complete or exhaustive resource, and it is not intended to serve as legal advice – so physicians should contact their medical malpractice insurance provider and/or their health care attorney for specific advice.

Is there a time limit on insurers' retroactive requests for payment recoveries?

Yes, a physician must be notified within 12 months of the date of service or discharge of an insurer's post-payment claim audit or retroactive claim denial – and it must be completed within 18 months – if a physician submits a claim for payment within 90 days of the last date of service or discharge included on the claim. If the claim was submitted for payment more than 90 days after the date of service or discharge, an insurer's post-payment claim audit or retroactive claim denial must be completed within 18 months of the claim submission date or 24 months after the date of service, whichever is sooner. §33-20A-62

When does a physician need to submit a claim to an insurer?

In Georgia, there is no timely submission law for filing claims with insurers. However, contractual timeliness provisions are typically included in physician contracts and in the insurance policy where a non- contracting provider is obtaining payment through an assignment of benefits. Georgia individual, blanket and group A&H policies have claims filing time limits – which are generally 20 days – unless it is not reasonably possible to file a claim within that time. §§33-24-17, 33-29-3(b)(5), 33-30-6(b)(2), 33-24-59.3, 33-30-23(e)

Is there a "continuity of care" law in Georgia?

Yes. Every physician-insurer contract must contain specific contract terminations provisions. If the physician or insurer terminates their contract, a patient who is being treated for a chronic illness has the right to receive treatment and care for a period of up to 60 days in accordance with the terms of the original contract. Any patient who receiving treatment and care for a pregnancy has the right to receive treatment for the duration of the pregnancy. §33-20A-61

Do insurers have to provide physicians with a specific notice and reason for an audit?

Yes. An insurer must provide a physician with a specific notice and reason for an audit or retroactive denial of payment. §33-20A-62

What does Georgia's "prompt pay" law require of insurers?

Georgia's prompt pay law requires insurers to pay physicians within 15 days for electronic claims or 30 days for paper claims. If the insurer denies the claim, they must send a letter or electronic notice which addresses the reasons for failing to pay the claim. This law does not apply to self-insured plans. §33-24-59.5

Is balance billing allowed in Georgia?

Georgia law includes a "patient hold harmless" statute that prohibits contracted physicians from pursuing enrollees for obligations that are the responsibility of the insurer. The law does not, however, prevent the physician from pursuing any amounts that are due from the patient as a result of unpaid cost sharing obligations (e.g., deductibles, copayments, coinsurance). §10-1-393(b)(30.1).

Can health insurers enter into preferred provider arrangements?

Yes. Under Georgia law, an insurer can enter into a preferred provider arrangement. A "preferred provider" is defined as a "health care provider or group of providers who have contracted to provide specified covered services." A "preferred provider arrangement" is a "contract between or on behalf of the health care insurer and a preferred provider." These arrangements allow preferred providers to furnish services at lower than usual fees in return for prompt payment and a certain volume of patients. §33-30-22

Can a physician be penalized for discussing medically necessary or appropriate care with a patient or assisting a patient who is disputing a claim that has been denied?

No. A physician is allowed to discuss medically necessary and appropriate care and assist a patient who is disputing an insurance claim that has been denied. §33-20A-7

Can insurers use financial incentives or disincentive programs to limit medically necessary or appropriate care?

No. An insurer cannot use a financial incentive/disincentive program to get a physician or hospital to order or provide less than medically necessary and appropriate care or for denying, reducing, limiting, or delaying such care. §33-20A-6

Do willing physicians have the right to become participating providers in health insurance plans?

Yes, Georgia has an "Any Willing Provider" law that allows every health care provider who is within a class that is approved by the health care corporation, who is appropriately licensed to practice, and who is reputable and in good standing to have the right to become a participating physician or approved health care provider for medical and/or surgical care under such terms or conditions as are imposed on other participating physicians or approved health care providers within such approved class under similar circumstances in accordance with this chapter. This law applies to health care corporations that are organized under Title 33, Chapter 20. §33-20-16

Can an insurer require physicians to seek prior authorization for emergency care?

No. Prior authorization can never be used as a condition for emergency services. This applies until the ER patient is stabilized. R. & Regs. r. 120-2-80-.06

Are insurers allowed to include "most favored nations" clauses in contracts?

No. Clauses that require a physician to give an insurer the lowest rate that he or she offers to other insurers or clauses that require physicians to charge other insurers higher prices for health care are not legal in Georgia. R. & Regs. r. 120-2-20-.03

Do physicians have to sign a contract with an "all products clause"?

No. Georgia law is silent on "all products clauses." A physician is not required to participate in "all products" that are offered by a health plan, but insurers are allowed to include these clauses in contracts. A physician should ensure that their contracts all state that they are only required to participate in that given plan.

Does Georgia define "medical necessity" – and are insurers required to use this definition?

Georgia law states that, "'Medical necessity,' 'medically necessary care,' or 'medically necessary and appropriate' means care based upon generally accepted medical practices in light of conditions at the time of treatment which is: (A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition; (B) Compatible with the standards of acceptable medical practice in the United States; (C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;(D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and (E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage." §33-20A-31. The law also provides that in determining whether a treatment is medically necessary and appropriate, an insurer must use the definition provided in by Georgia law. §33-20A-40

MAG members can contact MAG Legal Counsel Bethany Sherrer at 678.303.9273 or bsherrer@mag.org with any questions related to health insurance contracts.

With more than 8,000 members, MAG is the leading voice for physicians in Georgia. MAG represents physicians in every specialty and practice setting. Go to www.mag.org for details.

Updated August 15, 2019.