O.C.G.A. § 33-20A-62

*** Current through the 2006 Regular Session ***

TITLE 33. **INSURANCE**
CHAPTER 20A. MANAGED HEALTH CARE PLANS
ARTICLE 3. MANAGED HEALTH CARE PLANS

O.C.G.A. § 33-20A-62 (2006)

§ 33-20A-62. Payment

(a) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or **refund** due within 18 months of the last date of service or discharge covered by such claim.

(b) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted more than 90 days after the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since such claim was initially submitted by the claimant prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or **refund** due within the sooner of 18 months after the claimant's initial submission of such a claim or 24 months after the date of service.

(c) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's **request** for additional payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a **request** in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written **request** for additional payment or adjustment must be submitted within the earlier of 12 months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(d) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's **request** for additional payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a **request** in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted more than 90 days after the last date of service or discharge covered by such claim, the written **request** for additional payment or adjustment must be submitted within the earlier of six months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(e) An enrollee who is not billed for services by any provider, facility, or agent thereof within 45 days of the date that the provider, facility, or agent thereof knew that further payment was due as the result of a postpayment audit, retroactive denial, or rejected **request** to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a **request** for additional payment.

(f) Notwithstanding any other provision in this article to the contrary, when precertification has been obtained for a service, the insurer, carrier, plan, network, panel, or agent thereof shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment under Code Section 33-20A-7.1.

(g) Nothing in this article shall be construed as prohibiting reimbursement subject to Code Section 33-24-56.1.

HISTORY: Code 1981, § 33-20A-62, enacted by Ga. L. 2002, p. 441, § 9; Ga. L. 2003, p. 140, § 33.