



# OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER

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## DIRECTIVE 20-EX-7

TO: ALL INSURERS AUTHORIZED TO WRITE ACCIDENT AND HEALTH  
INSURANCE AND HEALTH BENEFIT PLANS IN THE STATE OF GEORGIA

FROM: JOHN F. KING  
INSURANCE AND SAFETY FIRE COMMISSIONER

DATE: MARCH 26, 2020

RE: TEMPORARY SUSPENSION OF CERTAIN UTILIZATION REVIEW AND  
NOTIFICATION REQUIREMENTS

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Governor Kemp has declared a public health emergency to help Georgia quickly and effectively contain the spread of COVID-19. As hospitals plan for high demand of inpatient hospital services and redeploy staff to provide direct patient care, their ability to perform certain administrative functions will be impacted. Moreover, with many hospitals delaying or suspending many scheduled procedures, the need for certain administrative functions is less necessary. The purpose of this Directive is to advise insurers authorized to write accident and health insurance in this state, health maintenance organizations, municipal cooperative health benefit plans, and prepaid health services plans (collectively “issuers”), independent agents performing utilization review under contract with such issuers, and licensed independent adjusters that certain utilization review and notification requirements should be suspended for 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops.

- 1. Suspension of Preauthorization Requirements for Scheduled Surgeries or Admissions at Hospitals.** Due to the increased demand for inpatient hospital services for COVID-19 patients, many hospitals are shifting staff resources from administrative functions to direct patient care. Issuers in Georgia are generally permitted to require preauthorization for health care services, other than emergency services. However, due to COVID-19, hospitals may lack the resources for staff to respond to utilization review requests for preauthorization while responding to the surge in patients. Therefore, the Department of Insurance (“Department”) is advising issuers that they should suspend preauthorization review for scheduled surgeries or admissions at hospitals for 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. However, hospitals should use their best efforts to provide 48 hours’ notice to the issuer after admission to a hospital,

including information necessary for an issuer to assist in coordinating care and discharge planning.

2. **Suspension of Concurrent Review for Inpatient Hospital Services.** Currently, issuers are permitted review services concurrently for medical necessity and to make determinations involving continued or extended health care services or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider within one business day of receipt of the necessary information. This review is known as concurrent review. Hospitals may lack the resources for staff to respond to utilization review requests for concurrent review while responding to the surge in patients due to COVID-19. Therefore, the Department is advising issuers that they should suspend concurrent review for inpatient hospital services provided for 60 days from the date of this Directive, subject to further evaluation as the COVID-19 situation develops.
3. **Suspension of Retrospective Review for Inpatient Hospital Services and Emergency Services at In-Network Hospitals and Payment of Claims.** Issuers may retrospectively review services for medical necessity and must make a determination involving health care services that have been delivered within 30 days of receipt of the necessary information. This review is known as retrospective review. Hospitals may lack the resources for staff to respond to utilization review requests for retrospective review while responding to the surge in patients due to COVID-19. Therefore, the Department is advising issuers that they should suspend retrospective review for inpatient hospital services and emergency services provided at in-network hospitals for 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers should pay claims from in-network hospitals that are otherwise eligible for payment without first reviewing the claims for medical necessity. Issuers may, to the extent necessary, request information to perform a retrospective review, reconcile claims, and make any payment adjustments beginning after 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. If an in-network hospital accepts payment for such claims, it should not enforce any contractual limitations regarding the permissibility of retrospective review or overpayment recovery. The timeframes for issuers to conduct a retrospective review or overpayment recovery should be extended for 60 days once retrospective review is resumed. Upon the resumption of retrospective review, issuers should take into consideration the circumstances involving the COVID-19 pandemic when reviewing such claims.
4. **Suspension of preauthorization requirements for post-acute placements, including but not limited to skilled nursing facilities, home health, acute rehabilitation, and long-term acute care.** As previously stated, issuers are permitted to require preauthorization for health care services other than emergency services. In order to permit hospitals to discharge patients to lower levels of care when medically appropriate, the Department is advising issuers that they should suspend preauthorization requirements for post-acute placements, including but not limited to, skilled nursing facilities, home health care services, acute rehabilitation services, and long-term acute care hospitals, following an inpatient hospital admission for 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers may review post-acute placements for medical necessity concurrently or retrospectively.

Issuers should keep in mind applicable regulations requiring a plan of care for home health care services be established and approved in writing by a physician. This requirement remains unchanged by this guidance, except to the extent that the State has permitted telehealth and verbal orders to suffice for this requirement for the duration of the COVID-19 emergency. Furthermore, issuers should provide hospitals with an up-to-date list of all in-network rehabilitation facilities, long-term acute care hospitals, and skilled nursing facilities to facilitate such discharges. Hospitals should use their best efforts to transfer insureds to in-network providers. An issuer may require the rehabilitation facility, skilled nursing facility, or long-term acute care hospital to provide notification of the admission to the issuer.

The purpose of this provision is to enable hospitals to readily discharge patients to lower levels of care when medically appropriate. Under normal circumstances it may take up to 7 days for hospitals to receive authorization to move a patient to the next level of care. This puts the patients at risk and also hinders a hospital's ability to efficiently discharge patients to make space available for COVID-19 and other patients in need of care.

5. **Waiver of credentialing by location for payers.** The Department urges issuers to waive any requirements for location-based credentialing for 60 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. This will allow providers to see patients in a variety of locations.
6. **Immediate Payment of Claims and Audits of Hospital Payments and Overpayment Recovery.** The Department urges issuers to pay claims as soon as possible. The Department understands that the COVID-19 emergency has put a great strain on issuers and providers, but issuers should do whatever possible to assist with the timely payment of claims. By doing so, hospitals can avoid the administrative burdens of repeated follow-ups with issuers.

Issuers typically audit payments to hospitals to ensure that such payments were proper. During the state of emergency for COVID-19, issuers should suspend non-essential audits of hospital payments. Issuers should toll time limits on overpayment recovery in, or any other agreed upon time limit between the hospital and issuers during the suspension.

7. **Applicability to Third-Party Administrators of Self-Funded Plans.** Adherence to this Directive is essential to ensure that hospitals are able to direct resources to patient care to handle increases in patient volume due to the COVID-19 state of emergency. Third-party administrators, which are licensed by the Department as independent adjusters, are strongly encouraged to apply the provisions of this circular letter to their administrative services arrangements with self-funded plans.



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INSURANCE AND SAFETY FIRE COMMISSIONER  
STATE OF GEORGIA