

WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Introduced

Senate Bill 267

By Senators Takubo, Grady, and Plymale

[Introduced January 17, 2023; referred
to the Committee on Health and Human Resources]

1 A BILL to amend and reenact §5-16-7f of the Code of West Virginia, as amended; to amend said
2 code by adding thereto a new section, designated §9-5-31; to amend and reenact §33-15-
3 4s of said code, to amend and reenact §33-16-3dd of said code; to amend and reenact
4 §33-24-7s of said code; to amend and reenact §33-25-8p of said code; and to amend and
5 reenact §33-25A-8s, all relating to prior authorizations; defining terms; requiring prior
6 authorizations and relating communications to be submitted via an electronic portal;
7 requiring electronic notification to the health care provider and insured confirming receipt
8 of the prior authorization; establishing timelines for compliance; providing communication
9 via the portal regarding the current status of the prior authorization; reducing time frames
10 for prior authorization requests; providing a time frame for a decision to be rendered after
11 the receipt of additional information; providing a time frame for a claim to be submitted to
12 audit or if the step therapy is incomplete; requiring a provider conducting peer review to be
13 licensed in West Virginia; revising the percentage approval for a health care provider to be
14 considered for an exemption from prior authorization criteria; removing criteria related to
15 electronic submission of pharmacy benefits; amending effective date; requiring oversight
16 and data collection by the Office of the Insurance Commissioner and the Inspector
17 General; and providing for civil penalties.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL;
BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
COMMISSIONS, OFFICES, PROGRAMS, ETC**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means ~~a specific medical problem, condition, or specific illness being~~
4 ~~managed including tests, procedures and rehabilitation initially requested by health care~~
5 ~~practitioner, to be performed at, the site of service, excluding out of network care: *Provided*, That~~
6 ~~any additional testing or procedures related or unrelated to the specific medical problem,~~
7 ~~condition, or specific illness being managed may require a separate prior authorization~~ means all
8 diagnostically related testing, procedures, and rehabilitation determined by the treating health
9 care practitioner to be medically necessary to treat a specific medical problem, condition, or
10 specific illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
13 States Department of Health and Human Services. Subsequently released versions may be used
14 provided that the new version is backward compatible with the current version approved by the
15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from the Public Employees
17 Insurance Agency about the coverage of a service or medication.

18 (b) The Public Employees Insurance Agency ~~is required to~~ shall develop require ~~prior~~
19 ~~authorization forms and portals~~ prior authorization forms, including any related communication, to
20 be submitted via an electronic portal and shall accept one prior authorization for an episode of
21 care. ~~These forms are required to~~ The portal shall be placed in an easily identifiable and
22 accessible place on the Public Employees Insurance Agency's webpage. ~~The forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
25 receipt of the prior authorization request ~~if~~ for ~~forms are submitted electronically;~~

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,

27 durable medical equipment, and anything else for which the Public Employees Insurance Agency
28 requires a prior authorization. ~~This list shall delineate those items which are bundled together as~~
29 ~~part of the episode of care.~~ The standard for including any matter on this list shall be science-
30 based using a nationally recognized standard. This list ~~is required to~~ shall be updated at least
31 quarterly to ensure that the list remains current;

32 (4) Inform the patient if the Public Employees Insurance Agency requires a plan member to
33 use step therapy protocols. This ~~must~~ shall be conspicuous on the prior authorization form. If the
34 patient has completed step therapy as required by the Public Employees Insurance Agency and
35 the step therapy has been unsuccessful, this shall be clearly indicated on the form, including
36 information regarding medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 (c) The Public Employees Insurance Agency shall ~~accept electronic prior authorization~~
39 ~~requests and respond to the request through electronic means by July 1, 2020.~~ The Public
40 Employees Insurance Agency is required to accept an electronically submitted prior authorization
41 and may not require more than one prior authorization form for an episode of care. If the Public
42 Employees Insurance Agency is currently accepting electronic prior authorization requests, the
43 Public Employees Insurance Agency shall have until January 1, 2020, to implement the provisions
44 of this section provide electronic communication via the portal regarding the current status of the
45 prior authorization request to the health care provider and the insured.

46 (d) ~~If the~~ After health care practitioner submits the request for prior authorization
47 electronically, and all of the information as required is provided, the Public Employees Insurance
48 Agency shall respond to the prior authorization request within ~~seven~~ two days from the day on the
49 electronic receipt of the prior authorization request, except that the Public Employees Insurance
50 Agency shall respond to the prior authorization request within ~~two days~~ a day if the request is for
51 medical care or other service for a condition where application of the time frame for making routine
52 or non-life-threatening care determinations is either of the following:

53 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
54 patient's psychological state; or

55 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
56 condition, would subject the patient to adverse health consequences without the care or treatment
57 that is the subject of the request.

58 (e) If the information submitted is considered incomplete, the Public Employees Insurance
59 Agency shall identify all deficiencies and within two business days from the day on the electronic
60 receipt of the prior authorization request return the prior authorization to the health care
61 practitioner. The health care practitioner shall provide the additional information requested within
62 three business days from the day the return request is received by the health care practitioner. The
63 Public Employees Insurance Agency shall render a decision within two business day after receipt
64 of the additional information submitted by the health care provider. If the health care practitioner
65 fails to submit additional information or the prior authorization is deemed considered denied and a
66 new request must shall be submitted.

67 (f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if
68 the information regarding step therapy is incomplete, the prior authorization may be transferred to
69 the peer review process, within two business days from the day on the electronic receipt of the
70 prior authorization request.

71 (g) A prior authorization approved by the Public Employees Insurance Agency is carried
72 over to all other managed care organizations and health insurers for three months, if the services
73 are provided within the state.

74 (h) The Public Employees Insurance Agency shall use national best practice guidelines to
75 evaluate a prior authorization.

76 (i) If a prior authorization is rejected by the Public Employees Insurance Agency and the
77 health care practitioner who submitted the prior authorization requests an appeal by peer review of
78 the decision to reject, the peer review shall be with a health care practitioner, licensed in West

79 Virginia, similar in specialty, education, and background. The Public Employees Insurance
80 Agency's medical director has the ultimate decision regarding the appeal determination and the
81 health care practitioner has the option to consult with the medical director after the peer-to- peer
82 consultation. Time frames regarding this appeal process shall take no longer than ~~30~~ three days.

83 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
84 authorization ~~shall~~ may not be subject to prior authorization requirements and shall be
85 immediately approved for not less than three days: *Provided*, That the cost of the medication does
86 not exceed \$5,000 per day and the health care practitioner shall note on the prescription or notify
87 the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
88 prior authorization ~~must~~ shall be obtained.

89 (2) If the approval of a prior authorization requires a medication substitution, the
90 substituted medication shall be as required under §30-5-1 et seq.

91 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
92 year and in a six-month time period has received a ~~400~~ 90 percent prior approval rating, the Public
93 Employees Insurance Agency ~~shall~~ may not require the health care practitioner to submit a prior
94 authorization for that procedure for the next six months. At the end of the six-month time frame,
95 the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at
96 any time, by the Public Employees Insurance Agency and may be rescinded if the Public
97 Employees Insurance Agency determines the health care practitioner is not performing the
98 procedure in conformity with the Public Employees Insurance Agency's benefit plan based upon
99 the results of the Public Employees Insurance Agency's internal audit.

100 ~~(l) The Public Employees Insurance Agency must accept and respond to electronically~~
101 ~~submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the Public~~
102 ~~Employees Insurance Agency is currently accepting electronic prior authorization requests, it shall~~
103 ~~have until January 1, 2020, to implement this provision. The Public Employees Insurance Agency~~
104 ~~shall accept and respond to prior authorizations through a secure electronic transmission using~~

105 ~~the NCPDP SCRIPT Standard ePA transactions.~~

106 (m) ~~(l)~~ This section is effective for policy, contract, plans, or agreements beginning on or
107 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
108 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
109 renewed in this state on or after the effective date of this section.

110 (n) ~~The timeframes in this section are not applicable to prior authorization requests~~
111 ~~submitted through telephone, mail, or fax.~~

112 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
113 needed, to oversee compliance with this article. The data shall include but not be limited to, prior
114 authorizations requested by health care providers, the total number of prior authorizations denied
115 broken down by health care provider, the total number of prior authorizations appealed by health
116 care providers, the total number of prior authorizations approved after appeal by health care
117 providers, the name of each gold card status physician, the name of each physician denied gold
118 card status, and the reason for such denial.

119 (n) The Insurance Commissioner may assess a civil penalty for a violation of this article.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-31. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means all diagnostically related testing, procedures, and rehabilitation
4 determined by the treating health care practitioner to be medically necessary to treat a specific
5 medical problem, condition, or specific illness to be performed at the site of service, excluding out
6 of network care.

7 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the

8 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
9 States Department of Health and Human Services. Subsequently released versions may be used
10 provided that the new version is backward compatible with the current version approved by the
11 United States Department of Health and Human Services;

12 "Prior Authorization" means obtaining advance approval from the Bureau of Medical
13 Services about the coverage of a service or medication.

14 (b) The Bureau of Medical Services shall require prior authorization forms, including any
15 related communication, to be submitted via an electronic portal and shall accept one prior
16 authorization for an episode of care. The portal shall be placed in an easily identifiable and
17 accessible place on the Bureau of Medical Services' webpage. The portal shall:

18 (1) Include instructions for the submission of clinical documentation;

19 (2) Provide an electronic notification to the health care provider and the insured confirming
20 receipt of the prior authorization request for forms submitted electronically;

21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
22 durable medical equipment, and anything else for which the Bureau of Medical Services requires a
23 prior authorization. The standard for including any matter on this list shall be science-based using
24 a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
25 remains current;

26 (4) Inform the patient if the Bureau of Medical Services requires a plan member to use step
27 therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has
28 completed step therapy as required by the Bureau of Medical Services and the step therapy has
29 been unsuccessful, this shall be clearly indicated on the form, including information regarding
30 medication or therapies which were attempted and were unsuccessful; and

31 (5) Be prepared by October 1, 2024.

32 (c) Provide electronic communication via the portal regarding the current status of the prior
33 authorization request to the health care provider and the insured.

34 (d) After health care practitioner submits the request for prior authorization electronically,
35 and all of the information as required is provided, the Bureau of Medical Services shall respond to
36 the prior authorization request within two days from the day on the electronic receipt of the prior
37 authorization request, except that the Bureau of Medical Services shall respond to the prior
38 authorization request within a day if the request is for medical care or other service for a condition
39 where application of the time frame for making routine or non-life-threatening care determinations
40 is either of the following:

41 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
42 patient's psychological state; or

43 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
44 condition, would subject the patient to adverse health consequences without the care or treatment
45 that is the subject of the request.

46 (e) If the information submitted is considered incomplete, the Bureau of Medical Services
47 shall identify all deficiencies and within two business days from the day on the electronic receipt of
48 the prior authorization request return the prior authorization to the health care practitioner. The
49 health care practitioner shall provide the additional information requested within three business
50 days from the day the return request is received by the health care practitioner. The Bureau of
51 Medical Services shall render a decision within two business days after receipt of the additional
52 information submitted by the health care provider. If the health care practitioner fails to submit
53 additional information the prior authorization is considered denied and a new request shall be
54 submitted.

55 (f) If the Bureau of Medical Services wishes to audit the prior authorization or if the
56 information regarding step therapy is incomplete, the prior authorization may be transferred to the
57 peer review process, within two business days from the day on the electronic receipt of the prior
58 authorization request.

59 (g) A prior authorization approved by the Bureau of Medical Services is carried over to all

60 other managed care organizations and health insurers for three months, if the services are
61 provided within the state.

62 (h) The Bureau of Medical Services shall use national best practice guidelines to evaluate
63 a prior authorization.

64 (i) If a prior authorization is rejected by the Bureau of Medical Services and the health care
65 practitioner who submitted the prior authorization requests an appeal by peer review of the
66 decision to reject, the peer review shall be with a health care practitioner, licensed in West Virginia,
67 similar in specialty, education, and background. The Bureau of Medical Services' medical director
68 has the ultimate decision regarding the appeal determination and the health care practitioner has
69 the option to consult with the medical director after the peer-to- peer consultation. Time frames
70 regarding this appeal process shall take no longer than three days.

71 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
72 authorization may not be subject to prior authorization requirements and shall be immediately
73 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
74 \$5,000 per day and the health care practitioner shall note on the prescription or notify the
75 pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
76 prior authorization shall be obtained.

77 (2) If the approval of a prior authorization requires a medication substitution, the
78 substituted medication shall be as required under §30-5-1 *et seq.* of this code

79 (k) If a health care practitioner has performed an average of 30 procedures per year and in
80 a six-month time period has received a 90 percent prior approval rating, the Bureau of Medical
81 Services may not require the health care practitioner to submit a prior authorization for that
82 procedure for the next six months. At the end of the six-month time frame, the exemption shall be
83 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the
84 Bureau of Medical Services and may be rescinded if the Bureau of Medical Services determines
85 the health care practitioner is not performing the procedure in conformity with the Bureau of

86 Medical Services' benefit plan based upon the results of the Bureau of Medical Services' internal
87 audit.

88 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
89 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
90 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
91 after the effective date of this section.

92 (m) The Inspector General shall request data on a quarterly basis, or more often as
93 needed, to oversee compliance with this article. The data shall include but not be limited to, prior
94 authorizations requested by health care providers, the total number of prior authorizations denied
95 broken down by health care provider, the total number of prior authorizations appealed by health
96 care providers, the total number of prior authorizations approved after appeal by health care
97 providers, the name of each gold card status physician, the name of each physician denied gold
98 card status, and the reason for such denial.

99 (n) The Inspector General may assess a civil penalty for a violation of this article.

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means ~~a specific medical problem, condition, or specific illness being~~
4 ~~managed including tests, procedures and rehabilitation initially requested by health care~~
5 ~~practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That~~
6 ~~any additional testing or procedures related or unrelated to the specific medical problem,~~
7 ~~condition, or specific illness being managed may require a separate prior authorization. means all~~
8 diagnostically related testing, procedures, and rehabilitation detrmind by the treating health care

9 practitioner to be medically necessary to treat a specific medical problem, condition, or specific
10 illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
13 States Department of Health and Human Services. Subsequently released versions may be used
14 provided that the new version is backward compatible with the current version approved by the
15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from a health insurer about the
17 coverage of a service or medication.

18 (b) ~~The health insurer is required to develop~~ shall require ~~prior authorization forms and~~
19 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
20 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~
21 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
22 insurer's webpage. ~~The forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
25 receipt of the prior authorization request ~~if for~~ forms are submitted electronically;

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
27 durable medical equipment, and anything else for which the health insurer requires a prior
28 authorization. ~~This list shall delineate those items which are bundled together as part of the~~
29 ~~episode of care.~~ The standard for including any matter on this list shall be science-based using a
30 nationally recognized standard. ~~This list is required to~~ shall be updated at least quarterly to ensure
31 that the list remains current;

32 (4) Inform the patient if the health insurer requires a plan member to use step therapy
33 protocols, as set forth in this chapter. ~~This must~~ shall be conspicuous on the prior authorization
34 form. If the patient has completed step therapy as required by the health insurer and the step

35 therapy has been unsuccessful, this shall be clearly indicated on the form, including information
36 regarding medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 (c) ~~The health insurer shall accept electronic prior authorization requests and respond to~~
39 ~~the request through electronic means by July 1, 2020. The health insurer is required to accept an~~
40 ~~electronically submitted prior authorization and may not require more than one prior authorization~~
41 ~~form for an episode of care. If the health insurer is currently accepting electronic prior authorization~~
42 ~~requests, the health insurer shall have until January 1, 2020, to implement the provisions of this~~
43 ~~section. Provide electronic communication via the portal regarding the current status of the prior~~
44 ~~authorization request to the health care provider and the insured.~~

45 (d) If After the health care practitioner submits the request for prior authorization
46 electronically, and all of the information as required is provided, the health insurer shall respond to
47 the prior authorization request within ~~seven~~ two days from the day on the electronic receipt of the
48 prior authorization request, except that the health insurer shall respond to the prior authorization
49 request within ~~two days~~ a day if the request is for medical care or other service for a condition
50 where application of the time frame for making routine or non-life-threatening care determinations
51 is either of the following:

52 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
53 patient's psychological state; or

54 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
55 condition would subject the patient to adverse health consequences without the care or treatment
56 that is the subject of the request.

57 (e) If the information submitted is considered incomplete, the health insurer shall identify all
58 deficiencies and within two business days from the day on the electronic receipt of the prior
59 authorization request return the prior authorization to the health care practitioner. The health care
60 practitioner shall provide the additional information requested within three business days from the

61 time the return request is received by the health care practitioner. The health insurer shall render a
62 decision within two business days after receipt of the additional information submitted by the
63 health care provider. If the health care provider fails to submit additional information or the prior
64 authorization is deemed considered denied and a new request must shall be submitted.

65 (f) If the health insurer wishes to audit the prior authorization or if the information regarding
66 step therapy is incomplete, the prior authorization may be transferred to the peer review process,
67 within two business days from the day on the electronic receipt of the prior authorization request.

68 (g) A prior authorization approved by a health insurer is carried over to all other managed
69 care organizations, health insurers and the Public Employees Insurance Agency for three months,
70 if the services are provided within the state.

71 (h) The health insurer shall use national best practice guidelines to evaluate a prior
72 authorization.

73 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
74 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
75 the peer review shall be with a health care practitioner, licensed in West Virginia, similar in
76 specialty, education, and background. The health insurer's medical director has the ultimate
77 decision regarding the appeal determination and the health care practitioner has the option to
78 consult with the medical director after the peer-to- peer consultation. Time frames regarding this
79 appeal process shall take no longer than ~~30~~ three days.

80 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
81 authorization ~~shall~~ may not be subject to prior authorization requirements and shall be
82 immediately approved for not less than three days: *Provided*, That the cost of the medication does
83 not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy
84 that the prescription is being provided at discharge. After the three-day time frame, a prior
85 authorization ~~must~~ shall be obtained.

86 (2) If the approval of a prior authorization requires a medication substitution, the

87 substituted medication shall be as required under §30-5-1 et seq.

88 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
89 year and in a six-month time period has received a ~~400~~ 90 percent prior approval rating, the health
90 insurer shall may not require the health care practitioner to submit a prior authorization for that
91 procedure for the next six months. At the end of the six-month time frame, the exemption shall be
92 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health
93 insurer and may be rescinded if the health insurer determines the health care practitioner is not
94 performing the procedure in conformity with the health insurer's benefit plan based upon the
95 results of the health insurer's internal audit.

96 ~~(l) The health insurer must accept and respond to electronically submitted prior~~
97 ~~authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently~~
98 ~~accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement~~
99 ~~this provision. The health insurer shall accept and respond to prior authorizations through a~~
100 ~~secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.~~

101 ~~(m)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or
102 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
103 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
104 renewed in this state on or after the effective date of this section.

105 ~~(n) The timeframes in this section are not applicable to prior authorization requests~~
106 ~~submitted through telephone, mail, or fax.~~

107 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
108 needed, to oversee compliance with this article. The data shall include but not be limited to, prior
109 authorizations requested by health care providers, the total number of prior authorizations denied
110 broken down by health care provider, the total number of prior authorizations appealed by health
111 care providers, the total number of prior authorizations approved after appeal by health care

112 providers, the name of each gold card status physician, the name of each physician denied gold
113 card status, and the reason for such denial.

114 (n) The Insurance Commissioner may assess a civil penalty for a violation of this article
115 pursuant to §33-3-11 of this code.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "~~Episode of Care" means a specific medical problem, condition, or specific illness being~~
4 ~~managed including tests, procedures, and rehabilitation initially requested by the health care~~
5 ~~practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That~~
6 ~~any additional testing or procedures related or unrelated to the specific medical problem,~~
7 ~~condition, or specific illness being managed may require a separate prior authorization. means all~~
8 diagnostically related testing, procedures, and rehabilitation determined by the treating health
9 care practitioner to be medically necessary to treat a specific medical problem, condition, or
10 specific illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
13 States Department of Health and Human Services. Subsequently released versions may be used
14 provided that the new version is backward compatible with the current version approved by the
15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from a health insurer about the
17 coverage of a service or medication.

18 (b)~~The health insurer is required to develop~~ shall require ~~prior authorization forms and~~
19 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
20 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~

21 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
22 insurer's webpage. The ~~forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
25 receipt of the prior authorization request ~~if for forms are~~ submitted electronically;

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
27 durable medical equipment, and anything else for which the health insurer requires a prior
28 authorization. ~~This list shall delineate those items which are bundled together as part of the~~
29 ~~episode of care.~~ The standard for including any matter on this list shall be science-based using a
30 nationally recognized standard. This list ~~is required to~~ shall be updated at least quarterly to ensure
31 that the list remains current;

32 (4) Inform the patient if the health insurer requires a plan member to use step therapy
33 protocols. This ~~must~~ shall be conspicuous on the prior authorization form. If the patient has
34 completed step therapy as required by the health insurer and the step therapy has been
35 unsuccessful, this shall be clearly indicated on the form, including information regarding
36 medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 ~~(c) The health insurer shall accept electronic prior authorization requests and respond to~~
39 ~~the request through electronic means by July 1, 2020. The health insurer is required to accept an~~
40 ~~electronically submitted prior authorization and may not require more than one prior authorization~~
41 ~~form for an episode of care. If the health insurer is currently accepting electronic prior authorization~~
42 ~~requests, the health insurer shall have until January 1, 2020, to implement the provisions of this~~
43 ~~section.~~ Provide electronic communication via the portal regarding the current status of the prior
44 authorization request to the health care provider and the insured.

45 (d) ~~If~~ After the health care practitioner submits the request for prior authorization
46 electronically, and all of the information as required is provided, the health insurer shall respond to

47 the prior authorization request within ~~seven~~ two days from the day on the electronic receipt of the
48 prior authorization request, except that the health insurer shall respond to the prior authorization
49 request within ~~two days~~ a day if the request is for medical care or other service for a condition
50 where application of the time frame for making routine or non-life-threatening care determinations
51 is either of the following:

52 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
53 patient's psychological state; or

54 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
55 condition, would subject the patient to adverse health consequences without the care or treatment
56 that is the subject of the request.

57 (e) If the information submitted is considered incomplete, the health insurer shall identify all
58 deficiencies and within two business days from the day on the electronic receipt of the prior
59 authorization request return the prior authorization to the health care practitioner. The health care
60 practitioner shall provide the additional information requested within three business days from the
61 time the return request is received by the health care practitioner. The health insurer shall render a
62 decision within two business days after receipt of the additional information submitted by the
63 health care provider. If the health care provider fails to submit additional information or the prior
64 authorization is deemed considered denied and a new request must shall be submitted.

65 (f) If the health insurer wishes to audit the prior authorization or if the information regarding
66 step therapy is incomplete, the prior authorization may be transferred to the peer review process,
67 within two business days from the day on the electronic receipt of the prior authorization request.

68 (g) A prior authorization approved by a managed care organization is carried over to health
69 insurers, the public employees insurance agency and all other managed care organizations for
70 three months if the services are provided within the state.

71 (h) The health insurer shall use national best practice guidelines to evaluate a prior
72 authorization.

73 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
74 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
75 the peer review shall be with a health care practitioner, licensed in West Virginia, similar in
76 specialty, education, and background. The health insurer's medical director has the ultimate
77 decision regarding the appeal determination and the health care practitioner has the option to
78 consult with the medical director after the peer-to- peer consultation. Time frames regarding this
79 appeal process shall take no longer than ~~30~~ three days.

80 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
81 authorization ~~shall~~ may not be subject to prior authorization requirements and shall be
82 immediately approved for not less than three days: *Provided*, That the cost of the medication does
83 not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy
84 that the prescription is being provided at discharge. After the three-day time frame, a prior
85 authorization ~~must~~ shall be obtained.

86 (2) If the approval of a prior authorization requires a medication substitution, the
87 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

88 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
89 year and in a six-month time period has received a ~~400~~ 90 percent prior approval rating, the health
90 insurer ~~shall~~ may not require the health care practitioner to submit a prior authorization for that
91 procedure for the next six months. At the end of the six-month time frame, the exemption shall be
92 reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at
93 any time and may be rescinded if the health insurer determines the health care practitioner is not
94 performing the procedure in conformity with the health insurer's benefit plan based upon the
95 results of the health insurer's internal audit.

96 ~~(l) The health insurer must accept and respond to electronically submitted prior~~
97 ~~authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently~~
98 ~~accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement~~

99 ~~this provision. The health insurer shall accept and respond to prior authorizations through a~~
100 ~~secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.~~

101 (m) (l) This section is effective for policy, contract, plans, or agreements beginning on or
102 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
103 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
104 renewed in this state on or after the effective date of this section.

105 (n) ~~The timeframes in this section are not applicable to prior authorization requests~~
106 ~~submitted through telephone, mail, or fax.~~

107 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
108 needed, to oversee compliance with this article. The data shall include but not be limited to, prior
109 authorizations requested by health care providers, the total number of prior authorizations denied
110 broken down by health care provider, the total number of prior authorizations appealed by health
111 care providers, the total number of prior authorizations approved after appeal by health care
112 providers, the name of each gold card status physician, the name of each physician denied gold
113 card status, and the reason for such denial.

114 (n) The Insurance Commissioner may assess a civil penalty for a violation of this article
115 pursuant to §33-3-11 of this code.

**ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE
CORPORATIONS, DENTAL SERVICE CORPORATIONS, AND HEALTH
SERVICE CORPORATIONS.**

§33-24-7s. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means ~~a specific medical problem, condition, or specific illness being~~
4 ~~managed including tests, procedures and rehabilitation initially requested by health care~~

5 practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That
6 any additional testing or procedures related or unrelated to the specific medical problem,
7 condition, or specific illness being managed may require a separate prior authorization. means all
8 diagnostically related testing, procedures, and rehabilitation determined by the treating health
9 care practitioner to be medically necessary to treat a specific medical problem, condition, or
10 specific illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
13 States Department of Health and Human Services. Subsequently released versions may be used
14 provided that the new version is backward compatible with the current version approved by the
15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from a health insurer about the
17 coverage of a service or medication.

18 (b) ~~The health insurer is required to develop~~ shall require prior authorization forms and
19 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
20 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~
21 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
22 insurer's webpage. ~~The forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
25 receipt of the prior authorization request if for forms are submitted electronically;

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
27 durable medical equipment and anything else for which the health insurer requires a prior
28 authorization. ~~This list shall delineate those items which are bundled together as part of the~~
29 ~~episode of care.~~ The standard for including any matter on this list shall be science-based using a
30 nationally recognized standard. ~~This list is required to~~ shall be updated at least quarterly to ensure

31 that the list remains current;

32 (4) Inform the patient if the health insurer requires a plan member to use step therapy
33 protocols. This ~~must~~ shall be conspicuous on the prior authorization form. If the patient has
34 completed step therapy as required by the health insurer and the step therapy has been
35 unsuccessful, this shall be clearly indicated on the form, including information regarding
36 medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 ~~(c) The health insurer shall accept electronic prior authorization requests and respond to~~
39 ~~the request through electronic means by July 1, 2020. The health insurer is required to accept an~~
40 ~~electronically submitted prior authorization and may not require more than one prior authorization~~
41 ~~form for an episode of care. If the health insurer is currently accepting electronic prior authorization~~
42 ~~requests, the health insurer shall have until January 1, 2020, to implement the provisions of this~~
43 ~~section. Provide electronic communication via the portal regarding the current status of the prior~~
44 ~~authorization request to the health care provider and the insured.~~

45 (d) If After the health care practitioner submits the request for prior authorization
46 electronically, and all of the information as required is provided, the health insurer shall respond to
47 the prior authorization request within ~~seven~~ two days from the day on the electronic receipt of the
48 prior authorization request, except that the health insurer shall respond to the prior authorization
49 request within ~~two days~~ a day if the request is for medical care or other service for a condition
50 where application of the time frame for making routine or non-life-threatening care determinations
51 is either of the following:

52 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
53 patient's psychological state; or

54 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
55 condition, would subject the patient to adverse health consequences without the care or treatment
56 that is the subject of the request.

57 (e) If the information submitted is considered incomplete, the health insurer shall identify all
58 deficiencies and within two business days from the day on the electronic receipt of the prior
59 authorization request return the prior authorization to the health care practitioner. The health care
60 practitioner shall provide the additional information requested within three business days from the
61 day the return request is received by the health care practitioner. The health insurer shall render a
62 decision within two business days after receipt of the additional information submitted by the
63 health care provider. If the health care provider fails to submit additional information or the prior
64 authorization is deemed ~~considered~~ denied and a new request must ~~shall~~ be submitted.

65 (f) If the health insurer wishes to audit the prior authorization or if the information regarding
66 step therapy is incomplete, the prior authorization may be transferred to the peer review process,
67 within two business days from the day on the electronic receipt of the prior authorization request.

68 (g) A prior authorization approved by a health insurer is carried over to all other managed
69 care organizations, health insurers and the Public Employees Insurance Agency for three months
70 if the services are provided within the state.

71 (h) The health insurer shall use national best practice guidelines to evaluate a prior
72 authorization.

73 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
74 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
75 the peer review shall be with a health care practitioner, licensed in West Virginia, similar in
76 specialty, education, and background. The health insurer's medical director has the ultimate
77 decision regarding the appeal determination and the health care practitioner has the option to
78 consult with the medical director after the peer-to-peer consultation. Time frames regarding this
79 appeal process shall take no longer than ~~30~~ three days.

80 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
81 authorization ~~shall~~ may not be subject to prior authorization requirements and shall be
82 immediately approved for not less than three days: *Provided*, That the cost of the medication does

83 not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy
84 that the prescription is being provided at discharge. After the three-day time frame, a prior
85 authorization ~~must~~ shall be obtained.

86 (2) If the approval of a prior authorization requires a medication substitution, the
87 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

88 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
89 year and in a six-month time period has received a ~~400~~ 90 percent prior approval rating, the health
90 insurer ~~shall~~ may not require the health care practitioner to submit a prior authorization for that
91 procedure for the next six months. At the end of the six-month time frame, the exemption shall be
92 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health
93 insurer and may be rescinded if the health insurer determines the health care practitioner is not
94 performing the procedure in conformity with the health insurer's benefit plan based upon the
95 results of the health insurer's internal audit.

96 ~~(l) The health insurer must accept and respond to electronically submitted prior~~
97 ~~authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently~~
98 ~~accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement~~
99 ~~this provision. The health insurer shall accept and respond to prior authorizations through a~~
100 ~~secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.~~

101 ~~(m) (l)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or
102 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
103 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
104 renewed in this state on or after the effective date of this section.

105 ~~(n) The timeframes in this section are not applicable to prior authorization requests~~
106 ~~submitted through telephone, mail, or fax.~~

107 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
108 needed, to oversee compliance with this article. The data shall include but not be limited to, prior

109 authorizations requested by health care providers, the total number of prior authorizations denied
 110 broken down by health care provider, the total number of prior authorizations appealed by health
 111 care providers, the total number of prior authorizations approved after appeal by health care
 112 providers, the name of each gold card status physician, the name of each physician denied gold
 113 card status, and the reason for such denial.

114 (n) The Insurance Commissioner may assess a civil penalty for a violation of this article
 115 pursuant to §33-3-11 of this code.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
 2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means ~~a specific medical problem, condition, or specific illness being~~
 4 ~~managed including tests, procedures and rehabilitation initially requested by health care~~
 5 ~~practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That~~
 6 ~~any additional testing or procedures related or unrelated to the specific medical problem,~~
 7 ~~condition, or specific illness being managed may require a separate prior authorization; means all~~
 8 diagnostically related testing, procedures, and rehabilitation determined by the treating health
 9 care practitioner to be medically necessary to treat a specific medical problem, condition, or
 10 specific illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
 12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
 13 States Department of Health and Human Services. Subsequently released versions may be used
 14 provided that the new version is backward compatible with the current version approved by the
 15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from a health insurer about the
 17 coverage of a service or medication.

18 (b) ~~The health insurer is required to develop~~ shall require ~~prior authorization forms and~~
19 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
20 electronic portal and shall accept one prior authorization for an episode of care. These forms are
21 ~~required to~~ shall be placed in an easily identifiable and accessible place on the health insurer's
22 webpage. The ~~forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
25 receipt of the prior authorization request if for forms are submitted electronically;

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
27 durable medical equipment and anything else for which the health insurer requires a prior
28 authorization. ~~This list shall delineate those items which are bundled together as part of the~~
29 ~~episode of care.~~ The standard for including any matter on this list shall be science-based using a
30 nationally recognized standard. ~~This list is required to~~ shall be updated at least quarterly to ensure
31 that the list remains current;

32 (4) Inform the patient if the health insurer requires a plan member to use step therapy
33 protocols. ~~This must~~ shall be conspicuous on the prior authorization form. If the patient has
34 completed step therapy as required by the health insurer and the step therapy has been
35 unsuccessful, this shall be clearly indicated on the form, including information regarding
36 medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 (c) ~~The health insurer shall accept electronic prior authorization requests and respond to~~
39 ~~the request through electronic means by July 1, 2020. The health insurer is required to accept an~~
40 ~~electronically submitted prior authorization and may not require more than one prior authorization~~
41 ~~form for an episode of care. If the health insurer is currently accepting electronic prior authorization~~
42 ~~requests, the health insurer shall have until January 1, 2020, to implement the provisions of this~~
43 ~~section.~~ Provide electronic communication via the portal regarding the current status of the prior

44 authorization request to the health care provider and the insured.

45 (d) If After the health care practitioner submits the request for prior authorization
46 electronically, and all of the information as required is provided, the health insurer shall respond to
47 the prior authorization request within ~~seven~~ two days from the day on the electronic receipt of the
48 prior authorization request, except that the health insurer shall respond to the prior authorization
49 request within ~~two days~~ a day if the request is for medical care or other service for a condition
50 where application of the time frame for making routine or non-life-threatening care determinations
51 is either of the following:

52 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
53 patient's psychological state; or

54 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
55 condition, would subject the patient to adverse health consequences without the care or treatment
56 that is the subject of the request.

57 (e) If the information submitted is considered incomplete, the health insurer shall identify all
58 deficiencies and within two business days from the day on the electronic receipt of the prior
59 authorization request return the prior authorization to the health care practitioner. The health care
60 practitioner shall provide the additional information requested within three business days from the
61 day the return request is received by the health care practitioner. The health insurer shall render a
62 decision within two business days after receipt of the additional information submitted by the
63 health care provider. If the health care provider fails to submit additional information or the prior
64 authorization is deemed considered denied and a new request ~~must~~ shall be submitted.

65 (f) If the health insurer wishes to audit the prior authorization or if the information regarding
66 step therapy is incomplete, the prior authorization may be transferred to the peer review process,
67 within two business days from the day on the electronic receipt of the prior authorization request.

68 (g) A prior authorization approved by a health insurer is carried over to all other managed
69 care organizations, health insurers and the Public Employees Insurance Agency for three months

70 if the services are provided within the state.

71 (h) The health insurer shall use national best practice guidelines to evaluate a prior
72 authorization.

73 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
74 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
75 the peer review shall be with a health care practitioner, licensed in West Virginia, similar in
76 specialty, education, and background. The health insurer's medical director has the ultimate
77 decision regarding the appeal determination and the health care practitioner has the option to
78 consult with the medical director after the peer-to-peer consultation. Time frames regarding this
79 appeal process shall take no longer than ~~30~~ three days.

80 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
81 authorization ~~shall~~ may not be subject to prior authorization requirements and shall be
82 immediately approved for not less than three days: *Provided*, That the cost of the medication does
83 not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy
84 that the prescription is being provided at discharge. After the three-day time frame, a prior
85 authorization ~~must~~ shall be obtained.

86 (2) If the approval of a prior authorization requires a medication substitution, the
87 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

88 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
89 year and in a six-month time period has received a ~~400~~ 90 percent prior approval rating, the health
90 insurer ~~shall~~ may not require the health care practitioner to submit a prior authorization for that
91 procedure for the next six months. At the end of the six-month time frame, the exemption shall be
92 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health
93 insurer and may be rescinded if the health insurer determines the health care practitioner is not
94 performing the procedure in conformity with the health insurer's benefit plan based upon the
95 results of the health insurer's internal audit.

96 ~~(l) The health insurer must accept and respond to electronically submitted prior~~
 97 ~~authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently~~
 98 ~~accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement~~
 99 ~~this provision. The health insurer shall accept and respond to prior authorizations through a~~
 100 ~~secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions~~

101 ~~(m) (l)~~ This section is effective for policy, contract, plans, or agreements beginning on or
 102 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
 103 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
 104 renewed in this state on or after the effective date of this section.

105 ~~(n) The timeframes in this section are not applicable to prior authorization requests~~
 106 ~~submitted through telephone, mail, or fax~~

107 ~~(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as~~
 108 ~~needed, to oversee compliance with this article. The data shall include but not be limited to, prior~~
 109 ~~authorizations requested by health care providers, the total number of prior authorizations denied~~
 110 ~~broken down by health care provider, the total number of prior authorizations appealed by health~~
 111 ~~care providers, the total number of prior authorizations approved after appeal by health care~~
 112 ~~providers, the name of each gold card status physician, the name of each physician denied gold~~
 113 ~~card status, and the reason for such denial.~~

114 ~~(n) The Insurance Commissioner may assess a civil penalty for a violation of this article~~
 115 ~~pursuant to §33-3-11 of this code.~~

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
 2 them in this section unless the context clearly indicates otherwise:

3 "Episode of Care" means ~~a specific medical problem, condition, or specific illness being~~
 4 ~~managed including tests, procedures and rehabilitation initially requested by health care~~

5 practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That
 6 any additional testing or procedures related or unrelated to the specific medical problem,
 7 condition, or specific illness being managed may require a separate prior authorization. means all
 8 diagnostically related testing, procedures, and rehabilitation determined by the treating health
 9 care practitioner to be medically necessary to treat a specific medical problem, condition, or
 10 specific illness to be performed at the site of service, excluding out of network care.

11 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
 12 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
 13 States Department of Health and Human Services. Subsequently released versions may be used
 14 provided that the new version is backward compatible with the current version approved by the
 15 United States Department of Health and Human Services;

16 "Prior Authorization" means obtaining advance approval from a health maintenance
 17 organization about the coverage of a service or medication.

18 (b) ~~The health maintenance organization is required to develop~~ shall require ~~prior~~
 19 ~~authorization forms and portals~~ prior authorization forms, including any related communication, to
 20 be submitted via an electronic portal and shall accept one prior authorization for an episode of
 21 care. These forms ~~are required to~~ shall be placed in an easily identifiable and accessible place on
 22 the health maintenance organization's webpage. The ~~forms~~ portal shall:

23 (1) Include instructions for the submission of clinical documentation;

24 (2) Provide an electronic notification to the health care provider and the insured confirming
 25 receipt of the prior authorization request if for forms are submitted electronically;

26 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
 27 durable medical equipment and anything else for which the health maintenance organization
 28 requires a prior authorization. ~~This list shall also delineate those items which are bundled together~~
 29 ~~as part of the episode of care.~~ The standard for including any matter on this list shall be science-
 30 based using a nationally recognized standard. This list ~~is required to~~ shall be updated at least

31 quarterly to ensure that the list remains current;

32 (4) Inform the patient if the health maintenance organization requires a plan member to use
33 step therapy protocols. This ~~must~~ shall be conspicuous on the prior authorization form. If the
34 patient has completed step therapy as required by the health maintenance organization and the
35 step therapy has been unsuccessful, this shall be clearly indicated on the form, including
36 information regarding medication or therapies which were attempted and were unsuccessful; and

37 (5) Be prepared by October 1, ~~2019~~ 2024.

38 ~~(c) The health maintenance organization shall accept electronic prior authorization~~
39 ~~requests and respond to the request through electronic means by July 1, 2020. The health~~
40 ~~maintenance organization is required to accept an electronically submitted prior authorization and~~
41 ~~may not require more than one prior authorization form for an episode of care. If the health~~
42 ~~maintenance organization is currently accepting electronic prior authorization requests, the health~~
43 ~~maintenance organization shall have until January 1, 2020, to implement the provisions of this~~
44 ~~section. Provide electronic communication via the portal regarding the current status of the prior~~
45 ~~authorization request to the health care provider and the insured.~~

46 (d) If After the health care practitioner submits the request for prior authorization
47 electronically, and all of the information as required is provided, the health maintenance
48 organization shall respond to the prior authorization request within ~~seven~~ two days from the day on
49 the electronic receipt of the prior authorization request, except that the health maintenance
50 organization shall respond to the prior authorization request within ~~two days~~ a day if the request is
51 for medical care or other service for a condition where application of the time frame for making
52 routine or non-life-threatening care determinations is either of the following:

53 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
54 patient's psychological state; or

55 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
56 condition, would subject the patient to adverse health consequences without the care or treatment

57 that is the subject of the request.

58 (e) If the information submitted is considered incomplete, the health maintenance
59 organization shall identify all deficiencies and within two business days from the day on the
60 electronic receipt of the prior authorization request return the prior authorization to the health care
61 practitioner. The health care practitioner shall provide the additional information requested within
62 three business days from the day the return request is received by the health care practitioner. The
63 health insurer shall render a decision within two business days after receipt of the additional
64 information submitted by the health care provider. If the health care provider fails to submit the
65 additional information ~~or~~ the prior authorization is ~~deemed~~ considered denied and a new request
66 ~~must~~ shall be submitted.

67 (f) If the health maintenance organization wishes to audit the prior authorization or if the
68 information regarding step therapy is incomplete, the prior authorization may be transferred to the
69 peer review process, within two business days from the day on the electronic receipt of the prior
70 authorization request.

71 (g) A prior authorization approved by a health maintenance organization is carried over to
72 all other managed care organizations, health insurers and the Public Employees Insurance
73 Agency for three months if the services are provided within the state.

74 (h) The health maintenance organization shall use national best practice guidelines to
75 evaluate a prior authorization.

76 (i) If a prior authorization is rejected by the health maintenance organization and the health
77 care practitioner who submitted the prior authorization requests an appeal by peer review of the
78 decision to reject, the peer review shall be with a health care practitioner, licensed in West Virginia,
79 similar in specialty, education, and background. The health maintenance organization's medical
80 director has the ultimate decision regarding the appeal determination and the health care
81 practitioner has the option to consult with the medical director after the peer-to-peer consultation.
82 Time frames regarding this appeal process shall take no longer than ~~30~~ three days.

83 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
84 authorization shall may not be subject to prior authorization requirements and shall be
85 immediately approved for not less than three days: *Provided*, That the cost of the medication does
86 not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy
87 that the prescription is being provided at discharge. After the three-day time frame, a prior
88 authorization ~~must~~ shall be obtained.

89 (2) If the approval of a prior authorization requires a medication substitution, the
90 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

91 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per
92 year and in a six-month time period has received a ~~100~~ 90 percent prior approval rating, the health
93 maintenance organization shall may not require the health care practitioner to submit a prior
94 authorization for that procedure for the next six months. At the end of the six-month time frame,
95 the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at
96 any time, by the health maintenance organization and may be rescinded if the health maintenance
97 organization determines the health care practitioner is not performing the procedure in conformity
98 with the health maintenance organization's benefit plan based upon the results of the health
99 maintenance organization's internal audit.

100 ~~(l) The health maintenance organization must accept and respond to electronically~~
101 ~~submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the health~~
102 ~~maintenance organization are currently accepting electronic prior authorization requests, it shall~~
103 ~~have until January 1, 2020, to implement this provision. The health maintenance organizations~~
104 ~~shall accept and respond to prior authorizations through a secure electronic transmission using~~
105 ~~the NCPDP SCRIPT Standard ePA transactions~~

106 ~~(m)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or
107 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or
108 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or

109 renewed in this state on or after the effective date of this section.

110 ~~(n) The timeframes in this section are not applicable to prior authorization requests~~
111 ~~submitted through telephone, mail, or fax~~

112 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
113 needed, to oversee compliance with this article. The data shall include but not be limited to, prior
114 authorizations requested by health care providers, the total number of prior authorizations denied
115 broken down by health care provider, the total number of prior authorizations appealed by health
116 care providers, the total number of prior authorizations approved after appeal by health care
117 providers, the name of each gold card status physician, the name of each physician denied gold
118 card status, and the reason for such denial.

119 (n) The Insurance Commissioner may assess a civil penalty for a violation of this article
120 pursuant to §33-3-11 of this code.

NOTE: The purpose of this bill is to update the law regarding prior authorizations. Provide a new definition regarding an episode of care, require the electronic submission of prior authorizations and related communications; include timeframes to streamline the prior authorization process during the process and the appeal process, provide for oversight and enforcement.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.