WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Committee Substitute

for

Senate Bill 442

BY SENATORS TAKUBO, MARONEY, STOLLINGS,

WOELFEL, AND PLYMALE

[Originating in the Committee on Health and Human

Resources; Reported on February 21, 2018]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §33-4-22, relating to regulating prior authorizations; defining terms; providing for electronically transmitted prior authorization forms; establishing procedures for submission and acceptance of forms; and setting deadlines.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4. GENERAL PROVISIONS.

§33-4-22. Prior authorization.

(a) For the purposes of this section "urgent care services" means a medical care or other service for a condition where application of the time frame for making routine or nonlife-threatening care determinations is either of the following:

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

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

(b) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers are required to develop prior authorization forms. These forms are required to be placed in an easily identifiable and accessible place on their web page. The forms shall include instructions for the submission of clinical documentation and provide an electronic notification confirming receipt of the prior authorization request. The forms shall be prepared by October 1, 2018.

(c) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2019.

(d) If the health care practitioner submits the request for prior authorization electronically, the insurer or plan shall respond to the prior authorization request within 24 hours for urgent care

services, or 168 hours for any prior approval request that is not for an urgent care service, from the time on the electronic receipt of the prior authorization request.

(e) If information submitted is considered incomplete, the health care practitioner shall provide the additional information requested within 72 hours from the time the request is received by the practitioner or the prior authorization is deemed denied and a new request must be submitted.

(f) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall make available on their web sites information about the policies, contracts, or agreements offered that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(g) A prior authorization approved by a managed care organization is carried over to all other managed care organizations for three months, if the services are provided within the state.

(h) The Public Employees Insurance Agency, managed care organizations, and private commercial insurers shall use national practice guidelines to evaluate a prior authorization.

(i) Any provision of a contractual arrangement entered into between an insurer or plan and a health care practitioner or beneficiary that is contrary to this section is unenforceable.

(j) This section is not applicable to submission of a prior authorization request through telephone, mail, or fax.