

# **WEST VIRGINIA LEGISLATURE**

## **2023 REGULAR SESSION**

**Introduced**

### **House Bill 2535**

By Delegates Summers, Tully, Forsht, and Petitto

[Introduced January 13, 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, 1931, as amended; to amend  
2 said code by adding thereto a new section, designated §9-5-31; to amend and reenact  
3 §33-15-4s of said code; to amend and reenact §33-16-3dd of said code; to amend and  
4 reenact §33-24-7s of said code; to amend and reenact §33-25-8p of said code; and to  
5 amend and reenact §33-25A-8s of said code, all relating to prior authorizations; defining  
6 terms; requiring prior authorizations and relating communications to be submitted via an  
7 electronic portal; requiring electronic notification to the health care provider and insured  
8 confirming receipt of the prior authorization; establishing timelines for compliance;  
9 providing communication via the portal regarding the current status of the prior  
10 authorization; reducing timeframes for prior authorization requests; providing a timeframe  
11 for a decision to be rendered after the receipt of additional information; providing a  
12 timeframe for a claim to be submitted to audit or if the step therapy is incomplete; requiring  
13 a provider conducting peer review to be licensed in West Virginia; revising the percentage  
14 approval for a health care provider to be considered for an exemption from prior  
15 authorization criteria; removing criteria related to electronic submission of pharmacy  
16 benefits; amending effective date; requiring oversight and data collection by the Office of  
17 the Insurance Commissioner and the Inspector General; 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-based  
30 using a nationally recognized standard. This list is required to be updated at least quarterly to  
31 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 be conspicuous on the prior authorization form. If the patient  
34 has completed step therapy as required by the Public Employees Insurance Agency 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 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 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 be subject to prior authorization requirements and shall be immediately  
85 approved for not less than three days: *Provided*, That the cost of the medication does not exceed  
86 \$5,000 per day and the health care practitioner shall note on the prescription or notify the  
87 pharmacy that the prescription is being provided at discharge. After the three-day time frame, a  
88 prior authorization must 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 ~~400~~ 90 percent prior approval rating, the Public  
93 Employees Insurance Agency ~~shall~~ may 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, the  
95 exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any  
96 time, by the Public Employees Insurance Agency and may be rescinded if the Public Employees  
97 Insurance Agency determines the health care practitioner is not performing the procedure in  
98 conformity with the Public Employees Insurance Agency's benefit plan based upon the results of  
99 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 ~~(m)~~ (m) The timeframes in this section are not applicable to prior authorization requests  
111 submitted through telephone, mail, or fax.

112 (n) 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 (o) 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 is required to be updated at least quarterly to ensure  
25 that the list remains current;

26 (4) Inform the patient if the Bureau of Medical Services requires a plan member to use step  
27 therapy protocols. This must 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 day 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 must 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 must 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 Bureau  
84 of Medical Services and may be rescinded if the Bureau of Medical Services determines the health  
85 care practitioner is not performing the procedure in conformity with the Bureau of Medical

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

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

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

98 (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 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 be updated at least quarterly to ensure that  
31 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 be conspicuous on the prior authorization form. If  
34 the patient has completed step therapy as required by the health insurer and the step therapy has  
35 been 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 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 be subject to prior authorization requirements and shall be immediately  
82 approved for not less than three days: *Provided*, That the cost of the medication does not exceed  
83 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the  
84 prescription is being provided at discharge. After the three-day time frame, a prior authorization  
85 must 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 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 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 be updated at least quarterly to ensure that  
31 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 be conspicuous on the prior authorization form. If the patient has completed  
34 step therapy as required by the health insurer and the step therapy has been unsuccessful, this  
35 shall be clearly indicated on the form, including information regarding medication or therapies  
36 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 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 be subject to prior authorization requirements and shall be immediately  
82 approved for not less than three days: *Provided*, That the cost of the medication does not exceed  
83 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the  
84 prescription is being provided at discharge. After the three-day time frame, a prior authorization  
85 must 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 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 be updated at least quarterly to ensure that  
31 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 be conspicuous on the prior authorization form. If the patient has completed  
34 step therapy as required by the health insurer and the step therapy has been unsuccessful, this  
35 shall be clearly indicated on the form, including information regarding medication or therapies  
36 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 (c) 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 (d) 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 be submitted.

65 (e) 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 (f) 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 (g) The health insurer shall use national best practice guidelines to evaluate a prior  
72 authorization.

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

85 must 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 ~~(j) 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 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)(k)~~ 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 (l) 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 (m) 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 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 be updated at least quarterly to ensure that  
31 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 be conspicuous on the prior authorization form. If the patient has completed  
34 step therapy as required by the health insurer and the step therapy has been unsuccessful, this  
35 shall be clearly indicated on the form, including information regarding medication or therapies  
36 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 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 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 be placed in an easily identifiable and accessible place on the  
22 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 be updated at least quarterly  
31 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 be conspicuous on the prior authorization form. If the patient has  
34 completed step therapy as required by the health maintenance organization and the step therapy  
35 has been 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 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 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 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 ~~400~~ 90 percent prior approval rating, the health  
93 maintenance organization ~~shall~~ may 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, the  
95 exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any  
96 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. This section applies to all policies, contracts, plans, or agreements, subject~~  
108 ~~to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on~~  
109 ~~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.