

WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

ENGROSSED

Committee Substitute

for

Senate Bill 267

BY SENATORS TAKUBO, GRADY, AND PLYMALE

[Originating in the Committee on Health and Human

Resources; reported on February 23, 2023]

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 confirming receipt of the prior
8 authorization; establishing timelines for compliance; providing communication via the
9 portal regarding the current status of the prior authorization; reducing time frames for prior
10 authorization requests; providing a time frame for a decision to be rendered after the
11 receipt of additional information; providing a time frame for a claim to be submitted to audit
12 or if the step therapy is incomplete; establishing time frame for peer-to-peer appeal;
13 reducing timeline for prior authorization appeal process; revising the percentage approval
14 for a health care provider to be considered for an exemption from prior authorization
15 criteria; revising time frame for prior authorization exemption process; removing limitation
16 on prior authorization exemption that applied exemption to procedures used to justify
17 granting of exemption; expanding auditing of prior authorization exemption process;
18 requiring plan to give health care practitioner rationale for revocation of exemption;
19 providing for limitations to exemption; removing criteria related to electronic submission of
20 pharmacy benefits; amending effective date; requiring oversight and data collection by the
21 Office of the Insurance Commissioner and the Inspector General; and providing for civil
22 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 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.

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

13 "Prior Authorization" means obtaining advance approval from the Public Employees
14 Insurance Agency ~~about~~ regarding the coverage of a service or medication.

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

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

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

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

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

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

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

44 (d) ~~If the~~ After the health care practitioner submits the request for prior authorization
45 electronically, and all of the information as required is provided, the Public Employees Insurance
46 Agency shall respond to the prior authorization request within ~~seven~~ five business days from the
47 day on the electronic receipt of the prior authorization request: ~~except that~~ Provided, That the

48 Public Employees Insurance Agency shall respond to the prior authorization request within ~~two~~
49 ~~days~~ two business days if the request is for medical care or other service for a condition where
50 application of the time frame for making routine or non-life-threatening care determinations is
51 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 Public Employees Insurance
58 Agency shall identify all deficiencies, and within two business days from the day on the electronic
59 receipt of the prior authorization, request return the prior authorization to the health care
60 practitioner. The health care practitioner shall provide the additional information requested within
61 three business days from the day the return request is received by the health care practitioner.
62 The Public Employees Insurance Agency shall render a decision within two business day after
63 receipt of the additional information submitted by the health care provider. If the health care
64 practitioner fails to submit additional information, or the prior authorization is ~~deemed~~ considered
65 denied and a new request ~~must~~ shall be submitted.

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

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

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

75 (i) If a prior authorization is rejected by the Public Employees Insurance Agency and the
76 health care practitioner who submitted the prior authorization requests an appeal by peer review
77 of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty,
78 education, and background. The Public Employees Insurance Agency's medical director has the
79 ultimate decision regarding the appeal determination and the health care practitioner has the
80 option to consult with the medical director after the peer-to-peer consultation. Time frames
81 regarding this peer-to-peer appeal process shall take no longer than ~~30~~ five business days from
82 the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a
83 decision on a prior authorization shall take no longer than 10 business days from the date of the
84 appeal submission.

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

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

93 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures
94 per year and in a six-month time period during that year has received a ~~400~~ 90 percent final prior
95 approval rating, the Public Employees Insurance Agency shall not require the health care
96 practitioner to submit a prior authorization ~~for that procedure~~ for at least the next six months, or
97 longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the six-
98 month time frame, or longer if the Public Employees Insurance Agency allows, the exemption

99 shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period
100 equal to the previously granted time period, or longer if the Public Employees Insurance Agency
101 allows. This exemption is subject to internal auditing, at any time, by the Public Employees
102 Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines
103 the health care practitioner is not performing ~~the~~ services or procedures in conformity with the
104 Public Employees Insurance Agency's benefit plan, it identifies substantial variances in historical
105 utilization, or identifies other anomalies based upon the results of the Public Employees Insurance
106 Agency's internal audit. The Public Employees Insurance Agency shall provide a health care
107 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
108 this subsection may be interpreted to prohibit the Public Employees Insurance Agency from
109 requiring a prior authorization for an experimental treatment, non-covered benefit, or any out-of-
110 network service or procedure.

111 ~~(l) The Public Employees Insurance Agency must accept and respond to electronically~~
112 ~~submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the Public~~
113 ~~Employees Insurance Agency is currently accepting electronic prior authorization requests, it shall~~
114 ~~have until January 1, 2020, to implement this provision. The Public Employees Insurance Agency~~
115 ~~shall accept and respond to prior authorizations through a secure electronic transmission using~~
116 ~~the NCPDP SCRIPT Standard ePA transactions.~~

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

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

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

125 prior authorizations requested by health care providers, the total number of prior authorizations
126 denied broken down by health care provider, the total number of prior authorizations appealed by
127 health care providers, the total number of prior authorizations approved after appeal by health
128 care providers, the name of each gold card status physician, and the name of each physician
129 whose gold card status was revoked and the reason for revocation.

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

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 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 medial problem, condition,
7 or specific illness being managed may require a separate prior authorization.

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

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

15 (b) The Bureau of Medical Services shall require prior authorization forms, including any
16 related communication, to be submitted via an electronic portal and shall accept one prior

17 authorization for an episode of care. The portal shall be placed in an easily identifiable and
18 accessible place on the Bureau of Medical Services' webpage and the portal web address shall
19 be included on the insured's insurance card. The portal shall:

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

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

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

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

33 (5) Be prepared by ~~October 1, 2024~~ July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
35 authorization request to the health care provider.

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

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

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

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

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

61 (g) A prior authorization approved by the Bureau of Medical Services is carried over to all
62 other managed care organizations and health insurers for three months if the services are
63 provided within the state.

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

66 (i) If a prior authorization is rejected by the Bureau of Medical Services and the health care
67 practitioner who submitted the prior authorization requests an appeal by peer review of the
68 decision to reject, the peer review shall be with a health care practitioner, similar in specialty,

69 education, and background. The Bureau of Medical Services' medical director has the ultimate
70 decision regarding the appeal determination and the health care practitioner has the option to
71 consult with the medical director after the peer-to- peer consultation. Time frames regarding this
72 peer-to-peer appeal process shall take no longer than five business days from the date of the
73 request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a
74 prior authorization shall take no longer than 10 business days from the date of the appeal
75 submission.

76 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
77 authorization may not be subject to prior authorization requirements and shall be immediately
78 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
79 \$5,000 per day and the health care practitioner shall note on the prescription or notify the
80 pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
81 prior authorization shall be obtained.

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

84 (k) If a health care practitioner has performed an average of 30 procedures per year and
85 in a six-month time period during that year has received a 90 percent final prior approval rating,
86 the Bureau of Medical Services may not require the health care practitioner to submit a prior
87 authorization for at least the next six months or longer if the Bureau for Medical Services allows:
88 *Provided*, That at the end of the six-month time frame, or longer if the Bureau for Medical Services
89 allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted
90 for a time period equal to the previously granted time period, or longer if the Bureau for Medical
91 Services allows. This exemption is subject to internal auditing at any time by the Bureau of Medical
92 Services and may be rescinded if the Bureau of Medical Services determines the health care
93 practitioner is not performing services or procedures in conformity with the Bureau of Medical
94 Services' benefit plan, it identifies substantial variances in historical utilization or identifies other

95 anomalies based upon the results of the Bureau of Medical Services' internal audit. The Bureau
96 for Medical Services shall provide a health care practitioner with a letter detailing the rationale for
97 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the
98 Bureau for Medical Services from requiring a prior authorization for an experimental treatment,
99 non-covered benefit, or any out-of-network service or procedure.

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

104 (m) The Inspector General shall request data on a quarterly basis, or more often as
105 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
106 authorizations requested by health care providers, the total number of prior authorizations denied
107 broken down by health care provider, the total number of prior authorizations appealed by health
108 care providers, the total number of prior authorizations approved after appeal by health care
109 providers, the name of each gold card status physician, and the name of each physician whose
110 gold card status was revoked and the reason for revocation.

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

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 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.

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

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

15 (b) ~~The health insurer is required to develop~~ shall require ~~prior authorization forms and~~
16 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
17 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~
18 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
19 insurer's webpage and the portal web address shall be included on the insured's insurance card.

20 The ~~forms~~ portal shall:

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

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

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

30 (4) Inform the patient if the health insurer requires a plan member to use step therapy
31 protocols as set forth in this chapter. This ~~must~~ shall be conspicuous on the prior authorization

32 form. If the patient has completed step therapy as required by the health insurer and the step
33 therapy has been unsuccessful, this shall be clearly indicated on the form, including information
34 regarding medication or therapies which were attempted and were unsuccessful; and

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

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

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

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

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

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

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

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

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

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

71 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
72 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
73 the peer review shall be with a health care practitioner, similar in specialty, education, and
74 background. The health insurer's medical director has the ultimate decision regarding the appeal
75 determination and the health care practitioner has the option to consult with the medical director
76 after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall
77 take no longer than ~~30~~ five business days from the date of the request of the peer-to-peer
78 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take
79 no longer than 10 business days from the date of the appeal submission.

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
89 per year and in a six-month time period during that year has received a ~~400~~ 90 percent final prior
90 approval rating, the health insurer ~~shall~~ may not require the health care practitioner to submit a
91 prior authorization ~~for that procedure~~ for at least the next six months, or longer if the insurer allows:
92 Provided, That at the end of the six-month time frame, or longer if the insurer allows, the
93 exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time
94 period equal to the previously granted time period, or longer if the insurer allows. This exemption
95 is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health
96 insurer determines the health care practitioner is not performing ~~the~~ services or procedures in
97 conformity with the health insurer's benefit plan, it identifies substantial variances in historical
98 utilization, or identifies other anomalies based upon the results of the health insurer's internal
99 audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for
100 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
101 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, or
102 any out-of-network service or procedure.

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

108 ~~(m)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or
109 after ~~January 1, 2020~~ January 1, 2024. This section applies to all policies, contracts, plans, or

110 agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or
111 renewed in this state on or after the effective date of this section.

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

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

121 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
122 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.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used

11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

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

15 (b)The health insurer ~~is required to develop~~ shall require ~~prior authorization forms and~~
16 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
17 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~
18 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
19 insurer's webpage and the portal web address shall be included on the insured's insurance card.

20 The ~~forms~~ portal shall:

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

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

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

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

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

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

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

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

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

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

61 health care provider. If the health care provider fails to submit additional information, or the prior
62 authorization is ~~deemed~~ considered denied and a new request ~~must~~ shall be submitted.

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

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

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

71 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
72 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
73 the peer review shall be with a health care practitioner, similar in specialty, education, and
74 background. The health insurer's medical director has the ultimate decision regarding the appeal
75 determination and the health care practitioner has the option to consult with the medical director
76 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall
77 take no longer than ~~30~~ five business days from the date of request of the peer-to-peer
78 consultation. Time frames regarding the appeal of a decision on a prior authorization shall taken
79 no longer than 10 business days from the date of the appeal submission.

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
89 per year and in a six-month time period during that year has received a ~~100~~ 90 percent final prior
90 approval rating, the health insurer ~~shall~~ may not require the health care practitioner to submit a
91 prior authorization ~~for that procedure~~ for at least the next six months, or longer if the insurer allows:
92 Provided, That, at the end of the six-month time frame, or longer if the insurer allows, the
93 exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time
94 period equal to the previously granted time period, or longer if the insurer allows. This exemption
95 is subject to internal auditing by the health insurer at any time and may be rescinded if the health
96 insurer determines the health care practitioner is not performing ~~the~~ services or procedures in
97 conformity with the health insurer's benefit plan, it identifies substantial variances in historical
98 utilization, or identifies or anomalies based upon the results of the health insurer's internal audit.
99 The insurer shall provide a health care practitioner with a letter detailing the rationale for
100 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
101 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, or
102 any out-of-network service or procedure.

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

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

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

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

121 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
122 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 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.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used

11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

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

15 (b)The health insurer ~~is required to develop~~ shall require ~~prior authorization forms and~~
16 ~~portals~~ prior authorization forms, including any related communication, to be submitted via an
17 electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are~~
18 ~~required to~~ The portal shall be placed in an easily identifiable and accessible place on the health
19 insurer's webpage and the portal web address shall be included on the insured's insurance card.

20 The ~~forms~~ portal shall:

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

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

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

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

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

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

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

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

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

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

61 health care provider. If the health care provider fails to submit additional information, or the prior
62 authorization is deemed ~~considered~~ denied and a new request ~~must~~ shall be submitted.

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

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

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

71 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
72 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
73 the peer review shall be with a health care practitioner, similar in specialty, education, and
74 background. The health insurer's medical director has the ultimate decision regarding the appeal
75 determination and the health care practitioner has the option to consult with the medical director
76 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall
77 take no longer than ~~30~~ five business days from the date of the request of the peer-to-peer
78 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take
79 no longer than 10 business days from the date of the appeal submission.

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
89 per year and in a six-month time period during that year has received a ~~100~~ 90 percent final prior
90 approval rating, the health insurer ~~shall~~ may not require the health care practitioner to submit a
91 prior authorization ~~for that procedure~~ for at least the next six months, or longer if the insurer allows:
92 Provided, That, at the end of the six-month time frame, or longer if the insurer allows, the
93 exemption shall be reviewed prior to renewal. If approved, this renewal, shall be granted for a
94 time period equal to the previously granted time period, or longer if the insurer allows. This
95 exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded
96 if the health insurer determines the health care practitioner is not performing ~~the~~ services or
97 procedures in conformity with the health insurer's benefit plan, it identifies substantial variances
98 in historical utilization or identifies other anomalies based upon the results of the health insurer's
99 internal audit. The insurer shall provide a health care practitioner with a letter detailing the
100 rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to
101 prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered
102 benefit, or any out-of-network service or procedure.

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

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

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

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

121 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
122 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 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.

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

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

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

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

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

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

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

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

36 (c) ~~The health insurer shall accept electronic prior authorization requests and respond to~~
37 ~~the request through electronic means by July 1, 2020~~. ~~The health insurer is required to accept an~~
38 ~~electronically submitted prior authorization and may not require more than one prior authorization~~

39 form for an episode of care. If the health insurer is currently accepting electronic prior authorization
40 requests, the health insurer shall have until January 1, 2020, to implement the provisions of this
41 section. Provide electronic communication via the portal regarding the current status of the prior
42 authorization request to the health care provider.

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

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

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

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

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

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

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

71 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
72 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
73 the peer review shall be with a health care practitioner, similar in specialty, education, and
74 background. The health insurer's medical director has the ultimate decision regarding the appeal
75 determination and the health care practitioner has the option to consult with the medical director
76 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall
77 take no longer than ~~30~~ five business days from the date of the request of the peer-to-peer
78 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take
79 no longer than 10 business days from the date of the appeal submission.

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
89 per year and in a six-month time period during that year has received a ~~400~~ 90 percent final prior
90 approval rating, the health insurer ~~shall~~ may not require the health care practitioner to submit a
91 prior authorization ~~for that procedure~~ for at least the next six months, or longer if the insurer allows:
92 Provided, That, at the end of the six-month time frame, or longer if the insurer allows, the
93 exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time
94 period equal to the previously granted time period, or longer is the insurer allows. This exemption
95 is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health
96 insurer determines the health care practitioner is not performing ~~the~~ services or procedures in
97 conformity with the health insurer's benefit plan, it identifies substantial variance in historical
98 utilization, or other anomalies based upon the results of the health insurer's internal audit. The
99 insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of
100 his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from
101 requiring a prior authorization for an experimental treatment, non-covered benefit, or any out-of-
102 network service or procedure.

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

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

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

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

121 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
122 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 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.

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

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

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

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

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

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

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

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

36 (c) ~~The health maintenance organization shall accept electronic prior authorization~~
37 ~~requests and respond to the request through electronic means by July 1, 2020~~. The health
38 ~~maintenance organization is required to accept an electronically submitted prior authorization and~~
39 ~~may not require more than one prior authorization form for an episode of care~~. If the health
40 ~~maintenance organization is currently accepting electronic prior authorization requests, the health~~

41 ~~maintenance organization shall have until January 1, 2020, to implement the provisions of this~~
42 ~~section.~~ Provide electronic communication via the portal regarding the current status of the prior
43 authorization request to the health care provider.

44 (d) If After the health care practitioner submits the request for prior authorization
45 electronically, and all of the information as required is provided, the health maintenance
46 organization shall respond to the prior authorization request within ~~seven~~ five business days from
47 the day on the electronic receipt of the prior authorization request, except that the health
48 maintenance organization shall respond to the prior authorization request within ~~two days~~ two
49 business days if the request is for medical care or other service for a condition where application
50 of the time frame for making routine or non-life-threatening care determinations is either of the
51 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 maintenance
58 organization shall identify all deficiencies, and within two business days from the day on the
59 electronic receipt of the prior authorization request, return the prior authorization to the health
60 care practitioner. The health care practitioner shall provide the additional information requested
61 within three business days from the day the return request is received by the health care
62 practitioner. The health insurer shall render a decision within two business days after receipt of
63 the additional information submitted by the health care provider. If the health care provider fails
64 to submit the additional information, ~~or~~ the prior authorization is ~~deemed~~ considered denied and
65 a new request ~~must~~ shall be submitted.

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

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

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

75 (i) If a prior authorization is rejected by the health maintenance organization and the health
76 care practitioner who submitted the prior authorization requests an appeal by peer review of the
77 decision to reject, the peer review shall be with a health care practitioner, similar in specialty,
78 education, and background. The health maintenance organization's medical director has the
79 ultimate decision regarding the appeal determination and the health care practitioner has the
80 option to consult with the medical director after the peer-to-peer consultation. Time frames
81 regarding this peer-to-peer appeal process shall take no longer than ~~30~~ five business days from
82 the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a
83 decision on a prior authorization shall take no longer than 10 business days from the date of the
84 appeal submission.

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

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

93 (k) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures
94 per year and in a six-month time period during that year has received a ~~400~~ 90 percent final prior
95 approval rating, the health maintenance organization ~~shall~~ may not require the health care
96 practitioner to submit a prior authorization ~~for that procedure~~ for at least the next six months or
97 longer if the insurer allows: *Provided, That* at the end of the six-month time frame, or longer if the
98 insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall
99 be granted for a time period equal to the previously granted tie period, or longer if the insurer
100 allows. This exemption is subject to internal auditing, at any time, by the health maintenance
101 organization and may be rescinded if the health maintenance organization determines the health
102 care practitioner is not performing ~~the~~ services or procedures in conformity with the health
103 maintenance organization's benefit plan, it identifies substantial variances in historical utilization,
104 or identifies other anomalies based upon the results of the health maintenance organization's
105 internal audit. The insurer shall provide a health care practitioner with a letter detailing the
106 rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to
107 prohibit an insurer from requiring prior authorization for an experimental treatment, non-covered
108 benefit, or any out-of-network service or procedure. This subsection shall not apply to services or
109 procedures where the benefit maximums or minimums have been required by statute or policy of
110 the Bureau for Medical Services as it relates to the Medicaid Program.

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

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

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

123 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often
124 as needed, to oversee compliance with this article. The data shall include, but not be limited to,
125 prior authorizations requested by health care providers, the total number of prior authorizations
126 denied broken down by health care provider, the total number of prior authorizations appealed by
127 health care providers, the total number of prior authorizations approved after appeal by health
128 care providers, the name of each gold card status physician, the name of each physician whose
129 gold card status was revoked and the reason for revocation.

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