

WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

ENROLLED

Committee Substitute

for

Senate Bill 267

By Senators Takubo, Grady, and Plymale

[Passed March 08, 2023; in effect 90 days from

passage]

1 AN ACT to amend and reenact §5-16-7f of the Code of West Virginia, 1931, as amended; to
2 amend said code by adding thereto a new section, designated §9-5-31; to amend and
3 reenact §33-15-4s of said code; to amend and reenact §33-16-3dd of said code; to amend
4 and 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 related communications to be submitted via an
7 electronic portal; requiring electronic notification to the health care provider confirming
8 receipt of the prior authorization; establishing timelines for compliance; providing
9 communication via the portal regarding the current status of the prior authorization;
10 reducing time frames for prior authorization requests; providing a time frame for a decision
11 to be rendered after the receipt of additional information; providing a time frame for a claim
12 to be submitted to audit; stating provisions pertaining to patient communications about
13 step therapy protocols; establishing time frame for peer-to-peer appeals; reducing timeline
14 for prior authorization appeal process; revising the percentage approval for a health care
15 provider to be considered for an exemption from prior authorization criteria; revising time
16 frame for prior authorization exemption process; removing limitation on prior authorization
17 exemption that applied exemption to procedures used to justify granting of exemption;
18 expanding auditing of prior authorization exemption process; requiring plan to give health
19 care practitioner rationale for revocation of exemption; providing for limitations to
20 exemption; removing criteria related to electronic submission of pharmacy benefits;
21 amending effective date; requiring oversight and data collection by the Office of the
22 Insurance Commissioner and the Inspector General; and providing for civil penalties.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL;**

**BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
COMMISSIONS, OFFICES, PROGRAMS, ETC**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

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

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed including tests, procedures, and rehabilitation initially requested by 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 regarding the coverage of a service or medication.

15 (b) The Public Employees Insurance Agency shall require prior authorization forms,
16 including any related communication, to be submitted via an electronic portal and shall accept one
17 prior authorization for an episode of care. The portal shall be placed in an easily identifiable and
18 accessible place on the Public Employees Insurance Agency's webpage and the portal web
19 address shall 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 Public Employees Insurance Agency
25 requires a prior authorization. The standard for including any matter on this list shall be science-
26 based using a nationally recognized standard. This list shall be updated at least quarterly to
27 ensure that the list remains current;

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

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

34 (c) The Public Employees Insurance Agency shall provide electronic communication via
35 the portal regarding the current status of the prior 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 Public Employees Insurance
38 Agency shall respond to the prior authorization request within five business days from the day on
39 the electronic receipt of the prior authorization request: *Provided*, That the Public Employees
40 Insurance Agency shall respond to the prior authorization request within two business days if the
41 request is for medical care or other service for a condition where application of the time frame for
42 making routine 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 Public Employees Insurance
49 Agency shall identify all deficiencies, and within two business days from the day on the electronic
50 receipt of the prior authorization, request return the prior authorization to the health care
51 practitioner. The health care practitioner shall provide the additional information requested within
52 three business days from the day the return request is received by the health care practitioner. The
53 Public Employees Insurance Agency shall render a decision within two business day after receipt
54 of the additional information submitted by the health care provider. If the health care practitioner
55 fails to submit additional information, the prior authorization is considered denied and a new
56 request shall be submitted.

57 (f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if
58 the information regarding step therapy is incomplete, the prior authorization may be transferred to
59 the 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 Public Employees Insurance Agency is carried
62 over to all other managed care organizations and health insurers for three months if the services
63 are provided within the state.

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

66 (i) If a prior authorization is rejected by the Public Employees Insurance Agency and the
67 health care practitioner who submitted the prior authorization requests an appeal by peer review of
68 the decision to reject, the peer review shall be with a health care practitioner, similar in specialty,
69 education, and background. The Public Employees Insurance Agency's medical director has the
70 ultimate decision regarding the appeal determination and the health care practitioner has the
71 option to consult with the medical director after the peer-to-peer consultation. Time frames
72 regarding this peer-to-peer appeal process shall take no longer than five business days from the
73 date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a

74 decision on a prior authorization shall take no longer than 10 business days from the date of the
75 appeal 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 in
85 a six-month time period during that year has received a 90 percent final prior approval rating, the
86 Public Employees Insurance Agency shall not require the health care practitioner to submit a prior
87 authorization for at least the next six months, or longer if the Public Employees Insurance Agency
88 allows: *Provided*, That at the end of the six-month time frame, or longer if the Public Employees
89 Insurance Agency allows, the exemption shall be reviewed prior to renewal. If approved, the
90 renewal shall be granted for a time period equal to the previously granted time period, or longer if
91 the Public Employees Insurance Agency allows. This exemption is subject to internal auditing, at
92 any time, by the Public Employees Insurance Agency and may be rescinded if the Public
93 Employees Insurance Agency determines the health care practitioner is not performing services or
94 procedures in conformity with the Public Employees Insurance Agency's benefit plan, it identifies
95 substantial variances in historical utilization, or identifies other anomalies based upon the results
96 of the Public Employees Insurance Agency's internal audit. The Public Employees Insurance
97 Agency shall provide a health care practitioner with a letter detailing the rationale for revocation of
98 his or her exemption. Nothing in this subsection may be interpreted to prohibit the Public
99 Employees Insurance Agency from requiring a prior authorization for an experimental treatment,

100 non-covered benefit, or any out-of-network service or procedure.

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

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

112 (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 be
19 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 a
25 prior authorization. The standard for including any matter on this list shall be science-based using
26 a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

28 (4) Inform the patient if the Bureau of Medical Services requires a plan member to use step
29 therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has
30 completed step therapy as required by the Bureau of Medical Services and the step therapy has
31 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 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 of
50 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 prior
74 authorization shall take no longer than 10 business days from the date of the appeal submission.

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

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

83 (k) If a health care practitioner has performed an average of 30 procedures per year and in
84 a six-month time period during that year has received a 90 percent final prior approval rating, the
85 Bureau of Medical Services may not require the health care practitioner to submit a prior
86 authorization for at least the next six months or longer if the Bureau for Medical Services allows:
87 *Provided*, That at the end of the six-month time frame, or longer if the Bureau for Medical Services

88 allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted
89 for a time period equal to the previously granted time period, or longer if the Bureau for Medical
90 Services allows. This exemption is subject to internal auditing at any time by the Bureau of Medical
91 Services and may be rescinded if the Bureau of Medical Services determines the health care
92 practitioner is not performing services or procedures in conformity with the Bureau of Medical
93 Services' benefit plan, it identifies substantial variances in historical utilization or identifies other
94 anomalies based upon the results of the Bureau of Medical Services' internal audit. The Bureau for
95 Medical Services shall provide a health care practitioner with a letter detailing the rationale for
96 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the
97 Bureau for Medical Services from requiring a prior authorization for an experimental treatment,
98 non-covered benefit, or any out-of-network service or procedure. (l) This section is effective for
99 policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies
100 to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed,
101 issued, amended, adjusted, or renewed in this state on or after the effective date of this section.
102 (m) The Inspector General shall request data on a quarterly basis, or more often as needed, to
103 oversee compliance with this article. The data shall include, but not be limited to, prior
104 authorizations requested by health care providers, the total number of prior authorizations denied
105 broken down by health care provider, the total number of prior authorizations appealed by health
106 care providers, the total number of prior authorizations approved after appeal by health care
107 providers, the name of each gold card status physician, and the name of each physician whose
108 gold card status was revoked and the reason for revocation.
109 (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 shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal and shall accept one prior authorization for
17 an episode of care. The portal shall be placed in an easily identifiable and accessible place on the
18 health insurer's webpage and the portal web address shall be included on the insured's insurance
19 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 health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list

27 remains current;

28 (4) Inform the patient if the health insurer requires a plan member to use step therapy
29 protocols as set forth in this chapter. This shall be conspicuous on the prior authorization form. If
30 the patient has completed step therapy as required by the health insurer and the step therapy has
31 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 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 health insurer shall respond to
38 the prior authorization request within five business days from the day on the electronic receipt of
39 the prior authorization request, except that the health insurer shall respond to the prior
40 authorization request within two business days if the request is for medical care or other service for
41 a condition where application of the time frame for making routine or non-life-threatening care
42 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 health insurer shall identify all
49 deficiencies, and within two business days from the day on the electronic receipt of the prior
50 authorization request return the prior authorization to the health care practitioner. The health care
51 practitioner shall provide the additional information requested within three business days from the
52 time the return request is received by the health care practitioner. The health insurer shall render a

53 decision within two business days after receipt of the additional information submitted by the
54 health care provider. If the health care provider fails to submit additional information, the prior
55 authorization is considered denied and a new request shall be submitted.

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

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

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

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

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

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

81 (k) If a health care practitioner has performed an average of 30 procedures per year and in
82 a six-month time period during that year has received a 90 percent final prior approval rating, the
83 health insurer may not require the health care practitioner to submit a prior authorization for at
84 least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month
85 time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If
86 approved, the renewal shall be granted for a time period equal to the previously granted time
87 period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by
88 the health insurer and may be rescinded if the health insurer determines the health care
89 practitioner is not performing services or procedures in conformity with the health insurer's benefit
90 plan, it identifies substantial variances in historical utilization, or identifies other anomalies based
91 upon the results of the health insurer's internal audit. The insurer shall provide a health care
92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
93 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an
94 experimental treatment, non-covered benefit, or any out-of-network service or procedure.

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

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

104 providers, the name of each gold card status physician, and the name of each physician whose
105 gold card status was revoked and the reason for revocation.

106 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
107 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 shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal and shall accept one prior authorization for
17 an episode of care. The portal shall be placed in an easily identifiable and accessible place on the
18 health insurer's webpage and the portal web address shall be included on the insured's insurance
19 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 health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

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

33 (5) Be prepared by 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 health insurer shall respond to
38 the prior authorization request within five business days from the day on the electronic receipt of
39 the prior authorization request: *Provided*, That the health insurer shall respond to the prior
40 authorization request within two business days if the request is for medical care or other service for
41 a condition where application of the time frame for making routine or non-life-threatening care
42 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 health insurer shall identify all
49 deficiencies, and within two business days from the day on the electronic receipt of the prior
50 authorization request, return the prior authorization to the health care practitioner. The health care
51 practitioner shall provide the additional information requested within three business days from the
52 time the return request is received by the health care practitioner. The health insurer shall render a
53 decision within two business days after receipt of the additional information submitted by the
54 health care provider. If the health care provider fails to submit additional information, the prior
55 authorization is considered denied and a new request shall be submitted.

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

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

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

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

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

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

81 (k) If a health care practitioner has performed an average of 30 procedures per year and in
82 a six-month time period during that year has received a 90 percent final prior approval rating, the
83 health insurer may not require the health care practitioner to submit a prior authorization for at
84 least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-
85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal.
86 If approved, the renewal shall be granted for a time period equal to the previously granted time
87 period, or longer if the insurer allows. This exemption is subject to internal auditing by the health
88 insurer at any time and may be rescinded if the health insurer determines the health care
89 practitioner is not performing services or procedures in conformity with the health insurer's benefit
90 plan, it identifies substantial variances in historical utilization, or identifies or anomalies based
91 upon the results of the health insurer's internal audit. The insurer shall provide a health care
92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
93 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an
94 experimental treatment, non-covered benefit, or any out-of-network service or procedure.

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

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

106 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
107 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 shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal and shall accept one prior authorization for
17 an episode of care. The portal shall be placed in an easily identifiable and accessible place on the
18 health insurer's webpage and the portal web address shall be included on the insured's insurance
19 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 health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

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

33 (5) Be prepared by October 1, 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 health insurer shall respond to
38 the prior authorization request within five business days from the day on the electronic receipt of

39 the prior authorization request: Provided, That the health insurer shall respond to the prior
40 authorization request within two business days if the request is for medical care or other service for
41 a condition where application of the time frame for making routine or non-life-threatening care
42 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 health insurer shall identify all
49 deficiencies, and within two business days from the day on the electronic receipt of the prior
50 authorization request return the prior authorization to the health care practitioner. The health care
51 practitioner shall provide the additional information requested within three business days from the
52 day the return request is received by the health care practitioner. The health insurer shall render a
53 decision within two business days after receipt of the additional information submitted by the
54 health care provider. If the health care provider fails to submit additional information, the prior
55 authorization is considered denied and a new request shall be submitted.

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

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

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

64 (i) If a prior authorization is rejected by the health insurer and the health care practitioner

65 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
66 the peer review shall be with a health care practitioner, similar in specialty, education, and
67 background. The health insurer's medical director has the ultimate decision regarding the appeal
68 determination and the health care practitioner has the option to consult with the medical director
69 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall
70 take no longer than five business days from the date of the request of the peer-to-peer
71 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no
72 longer than 10 business days from the date of the appeal submission.

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

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

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

91 upon the results of the health insurer's internal audit. The insurer shall provide a health care
92 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
93 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an
94 experimental treatment, non-covered benefit, or any out-of-network service or procedure.

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

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

106 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
107 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 shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal and shall accept one prior authorization for
17 an episode of care. These forms shall be placed in an easily identifiable and accessible place on
18 the health insurer's webpage and the portal web address shall be included on the insured's
19 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 health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

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

33 (5) Be prepared by 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 health insurer shall respond to
38 the prior authorization request within five business days from the day on the electronic receipt of
39 the prior authorization request: *Provided*, That the health insurer shall respond to the prior
40 authorization request within two business days if the request is for medical care or other service for
41 a condition where application of the time frame for making routine or non-life-threatening care
42 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 health insurer shall identify all
49 deficiencies, and within two business days from the day on the electronic receipt of the prior
50 authorization request, return the prior authorization to the health care practitioner. The health care
51 practitioner shall provide the additional information requested within three business days from the
52 day the return request is received by the health care practitioner. The health insurer shall render a
53 decision within two business days after receipt of the additional information submitted by the
54 health care provider. If the health care provider fails to submit additional information the prior
55 authorization is considered denied and a new request shall be submitted.

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

59 (g) A prior authorization approved by a health insurer is carried over to all other managed

60 care organizations, health insurers, and the Public Employees Insurance Agency for three months
61 if the services are provided within the state.

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

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

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

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

81 (k) If a health care practitioner has performed an average of 30 procedures per year and in
82 a six-month time period during that year has received a 90 percent final prior approval rating, the
83 health insurer may not require the health care practitioner to submit a prior authorization for at
84 least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-
85 month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal.

86 If approved, the renewal shall be granted for a time period equal to the previously granted time
87 period, or longer is the insurer allows. This exemption is subject to internal auditing, at any time, by
88 the health insurer and may be rescinded if the health insurer determines the health care
89 practitioner is not performing services or procedures in conformity with the health insurer's benefit
90 plan, it identifies substantial variance in historical utilization, or other anomalies based upon the
91 results of the health insurer's internal audit. The insurer shall provide a health care practitioner with
92 a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection
93 may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental
94 treatment, non-covered benefit, or any out-of-network service or procedure.

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

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

106 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
107 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 shall require prior authorization forms, including
16 any related communication, to be submitted via an electronic portal and shall accept one prior
17 authorization for an episode of care. These forms shall be placed in an easily identifiable and
18 accessible place on the health maintenance organization's webpage and the portal web address
19 shall 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 health maintenance organization
25 requires a prior authorization. The standard for including any matter on this list shall be science-
26 based using a nationally recognized standard. This list shall be updated at least quarterly to
27 ensure that the list remains current;

28 (4) Inform the patient if the health maintenance organization requires a plan member to use

29 step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has
30 completed step therapy as required by the health maintenance organization 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 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 health maintenance
38 organization shall respond to the prior authorization request within five business days from the day
39 on the electronic receipt of the prior authorization request, except that the health maintenance
40 organization shall respond to the prior authorization request within two business days if the
41 request is for medical care or other service for a condition where application of the time frame for
42 making routine 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 health maintenance
49 organization shall identify all deficiencies, and within two business days from the day on the
50 electronic receipt of the prior authorization request, return the prior authorization to the health care
51 practitioner. The health care practitioner shall provide the additional information requested within
52 three business days from the day the return request is received by the health care practitioner. The
53 health insurer 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 provider fails to submit the

55 additional information, the prior authorization is considered denied and a new request shall be
56 submitted.

57 (f) If the health maintenance organization 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 a health maintenance organization is carried over to
62 all other managed care organizations, health insurers, and the Public Employees Insurance
63 Agency for three months if the services are provided within the state.

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

66 (i) If a prior authorization is rejected by the health maintenance organization and the health
67 care 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 health maintenance organization's medical director has the
70 ultimate decision regarding the appeal determination and the health care practitioner has the
71 option to consult with the medical director after the peer-to-peer consultation. Time frames
72 regarding this peer-to-peer appeal process shall take no longer than five business days from the
73 date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a
74 decision on a prior authorization shall take no longer than 10 business days from the date of the
75 appeal 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 physician shall note on the prescription or notify the pharmacy that the
80 prescription is being provided at discharge. After the three-day time frame, a prior authorization

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

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

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

107 authorizations requested by health care providers, the total number of prior authorizations denied
108 broken down by health care provider, the total number of prior authorizations appealed by health
109 care providers, the total number of prior authorizations approved after appeal by health care
110 providers, the name of each gold card status physician, the name of each physician whose gold
111 card status was revoked and the reason for revocation.

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