

WEST VIRGINIA LEGISLATURE

2025 REGULAR SESSION

Introduced

Senate Bill 833

By Senator Chapman

[Introduced March 20, 2025; referred
to the Committee on Finance]

1 A BILL to amend and reenact §9-5-32 and §33-25A-8s of the Code of West Virginia, 1931, as
 2 amended, relating to prior authorization; and excluding pharmaceutical medication from
 3 the prior authorization gold card process.

Be it enacted by the Legislature of West Virginia:

CHAPTER 9. HUMAN SERVICES.

ARTICLE	5.	MISCELLANEOUS	PROVISIONS.
§9-5-32.		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

consult with the medical director after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

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

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

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Bureau of Medical Services may not require the health care practitioner to submit a prior authorization for at least the next six months or longer if the Bureau for Medical Services allows: *Provided*, That at the end of the six-month time frame, or longer if the Bureau for Medical Services allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Bureau for Medical Services allows. This exemption is subject to internal auditing at any time by the Bureau of Medical Services and may be rescinded if the Bureau of Medical Services determines the health care practitioner is not performing services or procedures in conformity with the Bureau of Medical Services' benefit plan, it identifies substantial variances in historical utilization or identifies other anomalies based upon the results of the Bureau of Medical Services' internal audit. The Bureau for Medical Services shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the

Bureau for Medical Services from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

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

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

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

CHAPTER 33. INSURANCE.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s.

Prior

authorization.

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

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

"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

authorization request to the health care provider.

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

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

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

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

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

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

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

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

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

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

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the 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 pharmaceutical medications or services or procedures where the benefit maximums
100 or minimums have been required by statute or policy of the Bureau for Medical Services as it
101 relates to the Medicaid Program.

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

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

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

NOTE: The purpose of this bill is to exclude pharmaceutical medication from the prior authorization gold card process.

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