

# **WEST VIRGINIA LEGISLATURE**

**2025 REGULAR SESSION**

**Enrolled**

**Committee Substitute**

**for**

**Senate Bill 833**

BY SENATOR CHAPMAN

[Passed April 11, 2025; in effect from passage]



1 AN ACT to amend and reenact §5-16-7f, §9-5-32, §33-15-4s, §33-16-3dd, §33-24-7s, §33-25-8p,  
2 and §33-25a-8s of the Code of West Virginia, 1931, as amended, relating to prior  
3 authorization; and clarifying that pharmaceutical medication is excluded from the prior  
4 authorization gold card process.

*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.

(b) The Public Employees Insurance Agency shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Public Employees Insurance Agency's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

(5) Be prepared by July 1, 2024.

(c) The Public Employees Insurance Agency shall 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 Public Employees Insurance Agency shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the Public Employees Insurance Agency 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 Public Employees Insurance Agency 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 Public Employees Insurance Agency shall render a decision within two business day after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

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

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

(i) If a prior authorization is rejected by the Public Employees Insurance Agency 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 Public Employees Insurance Agency'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 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 Public Employees Insurance Agency shall not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the six-month time frame, or longer if the Public Employees Insurance Agency 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 Public Employees Insurance Agency allows. This exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines the health care practitioner is not performing services or procedures in conformity with the Public Employees Insurance Agency's

benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the Public Employees Insurance Agency's internal audit. The Public Employees Insurance Agency 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 Public Employees Insurance Agency 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 Insurance Commissioner 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 Insurance Commissioner may assess a civil penalty for a violation of this section.

## **CHAPTER 9. HUMAN SERVICES.**

### **ARTICLE 5. MISCELLANEOUS PROVISIONS.**

#### **§9-5-32. 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 medial problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 2013<sup>10</sup> or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from the Bureau for Medical Services about the coverage of a service or medication.

(b) The Bureau for Medical Services shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Bureau for Medical Services' webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

(4) Inform the patient if the Bureau for Medical Services requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the Bureau for Medical Services and the step therapy



has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

(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 Bureau of Medical Services 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 Bureau of Medical Services 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 Bureau for Medical Services 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 Bureau for Medical Services shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

57 (f) If the Bureau for 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 for 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 for 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 for Medical Services 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 Bureau for 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 for 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 for  
92 Medical Services and may be rescinded if the Bureau for Medical Services determines the health  
93 care practitioner is not performing services or procedures in conformity with the Bureau for  
94 Medical Services' benefit plan, it identifies substantial variances in historical utilization or identifies  
95 other anomalies based upon the results of the Bureau for Medical Services' internal audit. The  
96 Bureau for Medical Services shall provide a health care practitioner with a letter detailing the  
97 rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to  
98 prohibit the Bureau for Medical Services from requiring a prior authorization for an experimental  
99 treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or  
100 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  
104 or after the effective date of this section.

105           (m) The Inspector General 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

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 15. ACCIDENT AND SICKNESS INSURANCE.**

#### **§33-15-4s. 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 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

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

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on

the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

(5) Be prepared by July 1, 2024.

(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 insurer 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 insurer 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 insurer 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 time 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 additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer 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 insurer 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 insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer 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 insurer'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 insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer 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 insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health insurer's internal audit. The insurer 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 an insurer 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 Insurance Commissioner 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 Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

## **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

### **§33-16-3dd. 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 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used



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

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

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

(5) Be prepared by July 1, 2024.

(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 insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer 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 insurer 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 time 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 additional information, the prior authorization is considered denied and a new request shall be submitted.

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

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

(i) If a prior authorization is rejected by the health insurer 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 insurer'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 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 insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-month time frame, or longer if the insurer 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 insurer allows. This exemption is subject to internal auditing by the health

insurer at any time and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies or anomalies based upon the results of the health insurer's internal audit. The insurer 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 an insurer 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 Insurance Commissioner 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 Insurance Commissioner may assess a civil penalty for a violation of this section 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.**

(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 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

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

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

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

(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 insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer 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 insurer 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 additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer 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 insurer 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 insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer 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 insurer'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.

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  
82 in a six-month time period during that year has received a 90 percent final prior approval rating,  
83 the health insurer may not require the health care practitioner to submit a prior authorization for  
84 at 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,  
88 by 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, pharmaceutical medication, or any out-of-network  
95 service or procedure.

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

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



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

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

## **ARTICLE 25. HEALTH CARE CORPORATIONS.**

### **§33-25-8p. 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 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

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

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

(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  
38 to the prior authorization request within five business days from the day on the electronic receipt  
39 of 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  
41 for 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  
49 all 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  
53 a 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

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 insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-month time frame, or longer if the insurer 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 insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variance in historical utilization, or other anomalies based upon the results of the health insurer's internal audit. The insurer 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 an insurer 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 Insurance Commissioner 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, the name of each physician whose gold card status was revoked and the reason for revocation.

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

## **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 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used

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

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

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

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

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

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

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

(5) Be prepared by July 1, 2024.

(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.

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  
85 in a six-month time period during that year has received a 90 percent final prior approval rating,  
86 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,  
91 at any time, by the health maintenance organization and may be rescinded if the health  
92 maintenance organization determines the health care practitioner is not performing services or  
93 procedures in conformity with the health maintenance organization's benefit plan, it identifies  
94 substantial variances in historical utilization, or identifies other anomalies based upon the results  
95 of the health maintenance organization's internal audit. The insurer shall provide a health care  
96 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in  
97 this subsection may be interpreted to prohibit an insurer from requiring prior authorization for an  
98 experimental treatment, non-covered benefit, or any out-of-network service or procedure. This  
99 subsection shall not apply to pharmaceutical medications or services or procedures where the  
100 benefit maximums or minimums have been required by statute or policy of the Bureau for Medical  
101 Services as it 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  
105 or after the effective date of this section.

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

The Clerk of the Senate and the Clerk of the House of Delegates hereby  
certify that the foregoing bill is correctly enrolled.

.....  
*Clerk of the Senate*

.....  
*Clerk of the House of Delegates*

Originated in the Senate.

In effect from passage.

.....  
*President of the Senate*

.....  
*Speaker of the House of Delegates*

\_\_\_\_\_

The within is ..... this the.....  
Day of ....., 2025.

.....  
*Governor*