

# **WEST VIRGINIA LEGISLATURE**

## **2026 REGULAR SESSION**

**Introduced**

### **Senate Bill 822**

By Senator Helton

[Introduced February 6, 2026; referred  
to the Committee on Health and Human Resources;  
and then to the Committee on Finance]

1 A BILL 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 authorizations; defining terms; revising gold card process to include hospitals or  
4 departments of hospitals; revising criteria to qualify for a gold card; extending time frame  
5 gold card is effective; establishing new effective date; revising data-reporting  
6 requirements; permitting provider to request that the Office of the Insurance Commissioner  
7 provide data related to performance metrics used to determine his or her gold card status;  
8 requiring the Office of the Insurance Commissioner to standardize the gold carding  
9 process; and increasing the civil penalty for violations.

*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, imaging, procedures, and rehabilitation initially requested by the health  
5 care practitioner, ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,  
6 That 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 with a cost over \$10,000.

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, hospital, or department within a hospital has performed an  
85 ~~average of 30 procedures submitted at least 10 prior authorizations~~ per year and in a six-month  
86 time period during that year has received a 90 percent final prior approval rating, the Public

87 Employees Insurance Agency shall not require the health care practitioner, hospital, or  
88 department within a hospital to submit a prior authorization for at least the next six 12 months, or  
89 longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the six 12-  
90 month time frame, or longer if the Public Employees Insurance Agency allows, the exemption shall  
91 be reviewed prior to renewal. The exemption shall be applied to the type one or type two national  
92 provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period  
93 equal to the previously granted time period, or longer if the Public Employees Insurance Agency  
94 allows. This exemption is subject to internal auditing, at any time, by the Public Employees  
95 Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines  
96 the health care practitioner is not performing services or procedures in conformity with the Public  
97 Employees Insurance Agency's benefit plan, it identifies substantial variances in historical  
98 utilization, or identifies other anomalies based upon the results of the Public Employees Insurance  
99 Agency's internal audit. The Public Employees Insurance Agency shall provide a health care  
100 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in  
101 this subsection may be interpreted to prohibit the Public Employees Insurance Agency from  
102 requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical  
103 medication, or any out-of-network service or procedure.

104 (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
105 January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
106 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
107 or after the effective date of this section.

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

113 providers, the name of each gold card status physician, hospital, or department within a hospital  
114 and the name of each physician, hospital, or department within a hospital whose gold card status  
115 was revoked and the reason for revocation. This information shall be made available in a machine-  
116 readable format.

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

118 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
119 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
120 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to  
121 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
122 request.

123 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
124 implement a standardized gold carding process for all payors.

125 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 for a per  
126 violation of this section.

## 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, <u>imaging</u> , procedures, and rehabilitation initially requested by the health		
5	care practitioner, <del>to be performed at the site of service</del> , excluding out-of-network care: <i>Provided</i> ,		
6	That any additional testing or procedures <del>related or</del> 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 Bureau for Medical  
14 Services about the coverage of a service or medication with a cost of \$10,000.

15 (b) The Bureau for 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 for Medical Services' webpage and the portal web address shall  
19 be included on the insured's insurance card. The portal shall:

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

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

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
24 durable medical equipment, and anything else for which the Bureau of Medical Services requires 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 for Medical Services 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 Bureau for 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 for 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 for  
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 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 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 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 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.

83 (k) If a health care practitioner, hospital, or department within a hospital has performed an  
84 average of 30 procedures submitted at least 10 prior authorizations per year and in a six-month  
85 time period during that year has received a 90 percent final prior approval rating, the Bureau for  
86 Medical Services may not require the health care practitioner, hospital, or department within a

87     hospital to submit a prior authorization for at least the next six 12 months or longer if the Bureau for  
88     Medical Services allows: *Provided*, That at the end of the six 12-month time frame, or longer if the  
89     Bureau for Medical Services allows, the exemption shall be reviewed prior to renewal. The  
90     exemption shall be applied to the type one or type two national provider identifier (NPI), as  
91     appropriate. If approved, the renewal shall be granted for a time period equal to the previously  
92     granted time period, or longer if the Bureau for Medical Services allows. This exemption is subject  
93     to internal auditing at any time by the Bureau for Medical Services and may be rescinded if the  
94     Bureau for Medical Services determines the health care practitioner is not performing services or  
95     procedures in conformity with the Bureau for Medical Services' benefit plan, it identifies substantial  
96     variances in historical utilization or identifies other anomalies based upon the results of the Bureau  
97     for Medical Services' internal audit. The Bureau for Medical Services shall provide a health care  
98     practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in  
99     this subsection may be interpreted to prohibit the Bureau for Medical Services from requiring a  
100    prior authorization for an experimental treatment, non-covered benefit, pharmaceutical  
101    medication, or any out-of-network service or procedure.

102            (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
103    January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
104    to 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 Inspector General 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, hospital, or department within a hospital  
112    and the name of each physician, hospital, or department within a hospital whose gold card status

113 was revoked and the reason for revocation. This information shall be made available in a machine-  
114 readable format.

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

116 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
117 for gold card status, but has not yet been awarded, it may request from the Inspector General the  
118 underlying source data and performance metrics used to determine his or her gold card status.

119 The OIC shall provide this information within 24 hours of the request.

120 (o) By January 1, 2027, the Inspector General shall implement a standardized gold carding  
121 process.

122 (p) The Inspector General may assess a civil penalty of up to \$10,000 per violation of this  
123 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, imaging, procedures, and rehabilitation initially requested by the health  
5 care practitioner, ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,  
6 That 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 with a cost of over \$10,000.

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.

81 (k) If a health care practitioner, hospital, or department within a hospital has performed an  
82 average of 30 procedures submitted at least 10 prior authorizations per year and in a six-month  
83 time period during that year has received a 90 percent final prior approval rating, the health insurer  
84 may not require the health care practitioner, hospital, or department within a hospital to submit a  
85 prior authorization for at least the next six 12 months, or longer if the insurer allows: *Provided,*  
86 That at the end of the six 12-month time frame, or longer if the insurer allows, the exemption shall  
87 be reviewed prior to renewal. The exemption shall be applied to the type one or type two national  
88 provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period  
89 equal to the previously granted time period, or longer if the insurer allows. This exemption is

90 subject to internal auditing, at any time, by the health insurer and may be rescinded if the health  
91 insurer determines the health care practitioner is not performing services or procedures in  
92 conformity with the health insurer's benefit plan, it identifies substantial variances in historical  
93 utilization, or identifies other anomalies based upon the results of the health insurer's internal  
94 audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for  
95 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an  
96 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,  
97 pharmaceutical medication, or any out-of-network service or procedure.

98 (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
99 January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
100 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
101 or after the effective date of this section.

102 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as  
103 needed, to 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, hospital, or department within a hospital  
108 and the name of each physician, hospital, or department within a hospital whose gold card status  
109 was revoked and the reason for revocation. This information shall be made available in a machine-  
110 readable format.

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

113 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
114 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
115 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to

116 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
117 request.

118 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
119 implement a standardized gold carding process for all payors.

120 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 per violation  
121 of this section.

## **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, imaging, procedures, and rehabilitation initially requested by the health  
5 care practitioner ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,  
6 That 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 with a cost of \$10,000.

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 take 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, hospital, or department within a hospital ~~has performed an~~  
82 ~~average of 30 procedures submitted at least 10 prior authorizations~~ per year and in a six-month  
83 time period during that year has received a 90 percent final prior approval rating, the health insurer  
84 may not require the health care practitioner, hospital, or department within a hospital to submit a  
85 prior authorization for at least the next six 12 months, or longer if the insurer allows: *Provided*,  
86 That, at the end of the six 12-month time frame, or longer if the insurer allows, the exemption shall  
87 be reviewed prior to renewal. The exemption shall be applied to the type one or type two national  
88 provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period  
89 equal to the previously granted time period, or longer if the insurer allows. This exemption is  
90 subject to internal auditing by the health insurer at any time and may be rescinded if the health  
91 insurer determines the health care practitioner is not performing services or procedures in  
92 conformity with the health insurer's benefit plan, it identifies substantial variances in historical  
93 utilization, or identifies or anomalies based upon the results of the health insurer's internal audit.  
94 The insurer shall provide a health care practitioner with a letter detailing the rationale for  
95 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an  
96 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,

97 pharmaceutical medication, or any out-of-network service or procedure.

98 (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
99 January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
100 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
101 or after the effective date of this section.

102 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as  
103 needed, to 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, hospital, or department within a hospital  
108 and the name of each physician, hospital, or department within a hospital whose gold card status  
109 was revoked and the reason for revocation. This information shall be made available in a machine-  
110 readable format.

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

113 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
114 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
115 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to  
116 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
117 request.

118 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
119 implement a standardized gold carding process for all payors.

120 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 per violation  
121 of this section.

## **ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE**

**CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.**

1

**§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, imaging, procedures, and rehabilitation initially requested by the health  
5 care practitioner ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,

6 That 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 with a cost over \$10,000.

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 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, hospital, or department within a hospital has performed an  
82 ~~average of 30 procedures submitted at least 10 prior authorizations~~ per year and in a six-month  
83 time period during that year has received a 90 percent final prior approval rating, the health insurer  
84 may not require the health care practitioner, hospital, or department within a hospital to submit a  
85 prior authorization for at least the next six 12 months, or longer if the insurer allows: *Provided*,  
86 That, at the end of the six 12-month time frame, or longer if the insurer allows, the exemption shall  
87 be reviewed prior to renewal. The exemption shall be applied to the type one or type two national  
88 provider identifier (NPI), as appropriate. If approved, this renewal, shall be granted for a time  
89 period equal to the previously granted time period, or longer if the insurer allows. This exemption is  
90 subject to internal auditing, at any time, by the health insurer and may be rescinded if the health  
91 insurer determines the health care practitioner is not performing services or procedures in  
92 conformity with the health insurer's benefit plan, it identifies substantial variances in historical  
93 utilization or identifies other anomalies based upon the results of the health insurer's internal audit.  
94 The insurer shall provide a health care practitioner with a letter detailing the rationale for  
95 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an  
96 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,  
97 pharmaceutical medication, or any out-of-network service or procedure.

98 (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
99 January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject

100 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
101 or after the effective date of this section.

102 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as  
103 needed, to 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, hospital, or department within a hospital  
108 the name of each physician, hospital, or department within a hospital whose gold card status was  
109 revoked and the reason for revocation. This information shall be made available in a machine-  
110 readable format.

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

113 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
114 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
115 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to  
116 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
117 request.

118 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
119 implement a standardized gold carding process for all payors.

120 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 per violation  
121 of this section.

<b>ARTICLE</b>	<b>25.</b>	<b>HEALTH</b>	<b>CARE</b>	<b>CORPORATIONS.</b>
<b>§33-25-8p.</b>		<b>Prior</b>		<b>authorization.</b>

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, imaging, procedures, and rehabilitation initially requested by the health  
5       care practitioner, ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,  
6       That 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 with a cost over \$10,000.

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, hospital, or department within a hospital has performed an  
82 ~~average of 30 procedures submitted at least 10 prior authorizations~~ per year and in a six-month  
83 time period during that year has received a 90 percent final prior approval rating, the health insurer  
84 may not require the health care practitioner, hospital, or department within a hospital to submit a  
85 prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided,*  
86 That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall  
87 be reviewed prior to renewal. The exemption shall be applied to the type one or type two national  
88 provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period  
89 equal to the previously granted time period, or longer if the insurer allows. This exemption is  
90 subject to internal auditing, at any time, by the health insurer and may be rescinded if the health  
91 insurer determines the health care practitioner is not performing services or procedures in  
92 conformity with the health insurer's benefit plan, it identifies substantial variance in historical  
93 utilization, or other anomalies based upon the results of the health insurer's internal audit. The  
94 insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of  
95 his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from  
96 requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical  
97 medication, or any out-of-network service or procedure.

98 (I) This section is effective for policy, contract, plans, or agreements beginning on or after  
99 January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
100 to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
101 or after the effective date of this section.

102 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as  
103 needed, to 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, hospital, or department within a hospital  
108 the name of each physician, hospital, or department within a hospital whose gold card status was  
109 revoked and the reason for revocation. This information shall be made available in a machine-  
110 readable format.

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

113 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
114 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
115 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to  
116 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
117 request.

118 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
119 implement a standardized gold carding process for all payors.

120 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 per violation  
121 of this section.

<b>ARTICLE</b>	<b>25A.</b>	<b>HEALTH</b>	<b>MAINTENANCE</b>	<b>ORGANIZATION</b>	<b>ACT.</b>
<b>§33-25A-8s.</b>			<b>Prior</b>		<b>authorization.</b>

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, imaging, procedures, and rehabilitation initially requested by the health  
5 care practitioner, ~~to be performed at the site of service~~, excluding out-of-network care: *Provided*,  
6 That 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 with a cost over \$10,000.

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, hospital, or department within a hospital has performed an  
85 ~~average of 30 procedures submitted at least 10 prior authorizations~~ per year and in a six-month  
86 time period during that year has received a 90 percent final prior approval rating, the health  
87 maintenance organization may not require the health care practitioner, hospital, or department

88    within a hospital to submit a prior authorization for at least the next six 12 months or longer if the  
89    insurer allows: *Provided*, That at the end of the six 12-month time frame, or longer if the insurer  
90    allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the  
91    type one or type two national provider identifier (NPI), as appropriate. If approved, the renewal  
92    shall be granted for a time period equal to the previously granted time period, or longer if the  
93    insurer allows. This exemption is subject to internal auditing, at any time, by the health  
94    maintenance organization and may be rescinded if the health maintenance organization  
95    determines the health care practitioner is not performing services or procedures in conformity with  
96    the health maintenance organization's benefit plan, it identifies substantial variances in historical  
97    utilization, or identifies other anomalies based upon the results of the health maintenance  
98    organization's internal audit. The insurer shall provide a health care practitioner with a letter  
99    detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be  
100   interpreted to prohibit an insurer from requiring prior authorization for an experimental treatment,  
101   non-covered benefit, or any out-of-network service or procedure. This subsection shall not apply to  
102   pharmaceutical medications or services or procedures where the benefit maximums or minimums  
103   have been required by statute or policy of the Bureau for Medical Services as it relates to the  
104   Medicaid Program.

105                (l) This section is effective for policy, contract, plans, or agreements beginning on or after  
106   January 1, 2024 2027. This section applies to all policies, contracts, plans, or agreements, subject  
107   to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
108   or after the effective date of this section.

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

114 providers, the name of each gold card status physician, hospital, or department within a hospital  
115 the name of each physician, hospital, or department within a hospital whose gold card status was  
116 revoked and the reason for revocation. This information shall be made available in a machine-  
117 readable format.

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

120 (n) If a health care practitioner, hospital, or department within a hospital believes it qualifies  
121 for gold card status, but has not yet been awarded, it may request from the West Virginia Office of  
122 the Insurance Commissioner (OIC) the underlying source data and performance metrics used to  
123 determine his or her gold card status. The OIC shall provide this information within 24 hours of the  
124 request.

125 (o) By January 1, 2027, the West Virginia Office of the Insurance Commissioner (OIC) shall  
126 implement a standardized gold carding process for all payors.

127 (p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 per violation  
128 of this section.

NOTE: The purpose of this bill is to expand the definition of episode of care and the definition of prior authorization; to revise the requirements for the gold card process to include a hospital, or a department within a hospital; to extend the timeframe for which the gold care is effective; to allow the Office of the Insurance Commissioner to respond within 24 hours if a gold card provider believes he or she has been improperly denied; to implement a standard gold card process; to increase fines; and to establish a new effective date.

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