

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

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.

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

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within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation.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

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

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

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

(p) The Insurance Commissioner may assess a civil penalty of up to \$10,000 for a per 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, imaging, 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 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 the Bureau for Medical Services about the coverage of a service or medication with a cost of \$10,000.

(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.

(f) If the Bureau for Medical Services 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 Bureau for Medical Services 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 Bureau for Medical Services shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Bureau for Medical Services 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 Bureau for Medical Services' 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, hospital, or department within a hospital has performed an ~~average of 30 procedures~~ submitted at least 10 prior authorizations per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Bureau for 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

was revoked and the reason for revocation.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

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

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

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

(p) The Inspector General may assess a civil penalty of up to \$10,000 per 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, imaging, 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 with a cost of over \$10,000.

(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, hospital, or department within a hospital has performed an ~~average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. 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~~ 2027. 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, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

(n) If a health care practitioner, hospital, or department within a hospital believes it qualifies for gold card status, but has not yet been awarded, it may request from the West Virginia Office of 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

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

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.

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, hospital, or department within a hospital ~~has performed an average of 30 procedures submitted at least 10 prior authorizations~~ 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. 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 2027. 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, hospital, or department within a hospital and the name of each physician, hospital, or department within a hospital whose gold card status was revoked and the reason for revocation. This information shall be made available in a machine-readable format.

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

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

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

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

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, imaging, 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 with a cost over \$10,000.

(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

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

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

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

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

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

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

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:

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

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.

(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, hospital, or department within a hospital has ~~performed an average of 30 procedures~~ submitted at least 10 prior authorizations 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, hospital, or department within a hospital to submit a prior authorization for at least the next ~~six~~ 12 months, or longer if the insurer allows: *Provided*, That, at the end of the ~~six~~ 12-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. The exemption shall be applied to the type one or type two national provider identifier (NPI), as appropriate. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer is 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~~ 2027. 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

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.

ARTICLE	25A.	HEALTH	MAINTENANCE	ORGANIZATION	ACT.
§33-25A-8s.			Prior		authorization.

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

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed including tests, 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

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 with a cost over \$10,000.

(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.

(g) A prior authorization approved by a health maintenance organization is carried over to

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

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

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

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

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

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