

Delegate Ellington, from the Committee of Conference on matters of disagreement between the two houses, as to

**Eng. House Bill No. 2351, Relating to regulating prior authorizations.**

Submitted the following report, which was received:

Your Committee of Conference on the disagreeing votes of the two houses as to the amendments of the Senate and the House of Delegates to Eng. House Bill No. 2351 having met, after full and free conference, have agreed to recommend and do recommend to their respective houses, as follows:

That the House and Senate recede from their positions, and agree to the same as follows:

**“CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE  
GOVERNOR, SECRETARY OF STATE, AND ATTORNEY GENERAL;  
BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,  
COMMISSIONS, OFFICES, PROGRAMS, ETC.**

**ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.**

**§5-16-7f. Prior authorization.**

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

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

8 “National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard” means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United  
10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the  
12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from the Public Employees  
14 Insurance Agency about the coverage of a service or medication.

15 (b) The Public Employees Insurance Agency is required to develop prior authorization  
16 forms and portals and shall accept one prior authorization for an episode of care. These forms  
17 are required to be placed in an easily identifiable and accessible place on the Public Employees  
18 Insurance Agency’s webpage. The forms shall:

- 19 (1) Include instructions for the submission of clinical documentation;
- 20 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
21 forms are submitted electronically;
- 22 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
23 durable medical equipment, and anything else for which the Public Employees Insurance Agency  
24 requires a prior authorization. This list shall delineate those items which are bundled together as  
25 part of the episode of care. The standard for including any matter on this list shall be science-  
26 based using a nationally recognized standard. This list is required to be updated at least quarterly  
27 to ensure that the list remains current;
- 28 (4) Inform the patient if the Public Employees Insurance Agency requires a plan member  
29 to use step therapy protocols. This must be conspicuous on the prior authorization form. If the  
30 patient has completed step therapy as required by the Public Employees Insurance Agency and  
31 the step therapy has been unsuccessful, this shall be clearly indicated on the form, including  
32 information regarding medication or therapies which were attempted and were unsuccessful; and  
33 (5) Be prepared by October 1, 2019.

34 (c) The Public Employees Insurance Agency shall accept electronic prior authorization  
35 requests and respond to the request through electronic means by July 1, 2020. The Public  
36 Employees Insurance Agency is required to accept an electronically submitted prior authorization  
37 and may not require more than one prior authorization form for an episode of care. If the Public  
38 Employees Insurance Agency is currently accepting electronic prior authorization requests, the  
39 Public Employees Insurance Agency shall have until January 1, 2020, to implement the provisions  
40 of this section.

41 (d) If the health care practitioner submits the request for prior authorization electronically,  
42 and all of the information as required is provided, the Public Employees Insurance Agency shall  
43 respond to the prior authorization request within seven days from the day on the electronic receipt  
44 of the prior authorization request, except that the Public Employees Insurance Agency shall  
45 respond to the prior authorization request within two days if the request is for medical care or  
46 other service for a condition where application of the time frame for making routine or non-life-  
47 threatening care determinations is either of the following:

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

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

53 (e) If the information submitted is considered incomplete, the Public Employees Insurance  
54 Agency shall identify all deficiencies and within two business days from the day on the electronic  
55 receipt of the prior authorization request return the prior authorization to the health care  
56 practitioner. The health care practitioner shall provide the additional information requested within  
57 three business days from the day the return request is received by the health care practitioner or  
58 the prior authorization is deemed denied and a new request must be submitted.

59 (f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if  
60 the information regarding step therapy is incomplete, the prior authorization may be transferred  
61 to the peer review process.

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

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

67 (i) If a prior authorization is rejected by the Public Employees Insurance Agency and the  
68 health care practitioner who submitted the prior authorization requests an appeal by peer review  
69 of the decision to reject, the peer review shall be with a health care practitioner similar in specialty,  
70 education, and background. The Public Employees Insurance Agency's medical director has the  
71 ultimate decision regarding the appeal determination and the health care practitioner has the  
72 option to consult with the medical director after the peer-to- peer consultation. Time frames  
73 regarding this appeal process shall take no longer than 30 days.

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

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

82 (k) In the event a health care practitioner has performed an average of 30 procedures per  
83 year and in a six-month time period has received a 100 percent prior approval rating, the Public  
84 Employees Insurance Agency shall not require the health care practitioner to submit a prior

85 authorization for that procedure for the next six months. At the end of the six-month time frame,  
86 the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing,  
87 at any time, by the Public Employees Insurance Agency and may be rescinded if the Public  
88 Employees Insurance Agency determines the health care practitioner is not performing the  
89 procedure in conformity with the Public Employees Insurance Agency’s benefit plan based upon  
90 the results of the Public Employees Insurance Agency’s internal audit.

91 (l) The Public Employees Insurance Agency must accept and respond to electronically  
92 submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the Public  
93 Employees Insurance Agency is currently accepting electronic prior authorization requests, it shall  
94 have until January 1, 2020, to implement this provision. The Public Employees Insurance Agency  
95 shall accept and respond to prior authorizations through a secure electronic transmission using  
96 the NCPDP SCRIPT Standard ePA transactions.

97 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
98 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
100 or after the effective date of this section.

101 (n) The timeframes in this section are not applicable to prior authorization requests  
102 submitted through telephone, mail, or fax.

## **CHAPTER 33. INSURANCE.**

### **ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.**

#### **§33-15-4s. Prior authorization.**

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

3 “Episode of Care” means a specific medical problem, condition, or specific illness being  
4 managed including tests, procedures and rehabilitation initially requested by health care

5 practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That  
6 any additional testing or procedures related or unrelated to the specific medical problem,  
7 condition, or specific illness being managed may require a separate prior authorization.

8 “National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard” means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United  
10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the  
12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from a health insurer about the  
14 coverage of a service or medication.

15 (b)The health insurer is required to develop prior authorization forms and portals and shall  
16 accept one prior authorization for an episode of care. These forms are required to be placed in  
17 an easily identifiable and accessible place on the health insurer’s webpage. The forms shall:

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

19 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
20 forms are submitted electronically;

21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
22 durable medical equipment, and anything else for which the health insurer requires a prior  
23 authorization. This list shall delineate those items which are bundled together as part of the  
24 episode of care. The standard for including any matter on this list shall be science-based using  
25 a nationally recognized standard. This list is required to be updated at least quarterly to ensure  
26 that the list remains current;

27 (4) Inform the patient if the health insurer requires a plan member to use step therapy  
28 protocols, as set forth in this chapter. This must be conspicuous on the prior authorization form.  
29 If the patient has completed step therapy as required by the health insurer and the step therapy  
30 has been unsuccessful, this shall be clearly indicated on the form, including information regarding

31 medication or therapies which were attempted and were unsuccessful; and

32 (5) Be prepared by October 1, 2019.

33 (c) The health insurer shall accept electronic prior authorization requests and respond to  
34 the request through electronic means by July 1, 2020. The health insurer is required to accept an  
35 electronically submitted prior authorization and may not require more than one prior authorization  
36 form for an episode of care. If the health insurer is currently accepting electronic prior authorization  
37 requests, the health insurer shall have until January 1, 2020, to implement the provisions of this  
38 section.

39 (d) If the health care practitioner submits the request for prior authorization electronically,  
40 and all of the information as required is provided, the health insurer shall respond to the prior  
41 authorization request within seven days from the day on the electronic receipt of the prior  
42 authorization request, except that the health insurer shall respond to the prior authorization  
43 request within two days if the request is for medical care or other service for a condition where  
44 application of the time frame for making routine or non-life-threatening care determinations is  
45 either of the following:

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

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

51 (e) If the information submitted is considered incomplete, the health insurer shall identify  
52 all deficiencies and within two business days from the day on the electronic receipt of the prior  
53 authorization request return the prior authorization to the health care practitioner. The health care  
54 practitioner shall provide the additional information requested within three business days from the  
55 time the return request is received by the health care practitioner or the prior authorization is  
56 deemed denied and a new request must be submitted.

57 (f) If the health insurer wishes to audit the prior authorization or if the information regarding  
58 step therapy is incomplete, the prior authorization may be transferred to the peer review process.

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 appeal process shall take no  
70 longer than 30 days.

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

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

79 (k) In the event a health care practitioner has performed an average of 30 procedures per  
80 year and in a six-month time period has received a 100 percent prior approval rating, the health  
81 insurer shall not require the health care practitioner to submit a prior authorization for that  
82 procedure for the next six months. At the end of the six-month time frame, the exemption shall



83 be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the  
84 health insurer and may be rescinded if the health insurer determines the health care practitioner  
85 is not performing the procedure in conformity with the health insurer's benefit plan based upon  
86 the results of the health insurer's internal audit.

87 (l) The health insurer must accept and respond to electronically submitted prior  
88 authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently  
89 accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement  
90 this provision. The health insurer shall accept and respond to prior authorizations through a secure  
91 electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

92 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
93 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
94 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
95 or after the effective date of this section.

96 (n) The timeframes in this section are not applicable to prior authorization requests  
97 submitted through telephone, mail, or fax.

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

### **§33-16-3dd. Prior authorization.**

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

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

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United

10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the  
12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from a health insurer about the  
14 coverage of a service or medication.

15 (b)The health insurer is required to develop prior authorization forms and portals and shall  
16 accept one prior authorization for an episode of care. These forms are required to be placed in  
17 an easily identifiable and accessible place on the health insurer’s webpage. The forms shall:

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

19 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
20 forms are submitted electronically;

21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
22 durable medical equipment, and anything else for which the health insurer requires a prior  
23 authorization. This list shall delineate those items which are bundled together as part of the  
24 episode of care. The standard for including any matter on this list shall be science-based using  
25 a nationally recognized standard. This list is required to be updated at least quarterly to ensure  
26 that the list remains current;

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

32 (5) Be prepared by October 1, 2019.

33 (c) The health insurer shall accept electronic prior authorization requests and respond to  
34 the request through electronic means by July 1, 2020. The health insurer is required to accept an  
35 electronically submitted prior authorization and may not require more than one prior authorization

36 form for an episode of care. If the health insurer is currently accepting electronic prior authorization  
37 requests, the health insurer shall have until January 1, 2020, to implement the provisions of this  
38 section.

39 (d) If the health care practitioner submits the request for prior authorization electronically,  
40 and all of the information as required is provided, the health insurer shall respond to the prior  
41 authorization request within seven days from the day on the electronic receipt of the prior  
42 authorization request, except that the health insurer shall respond to the prior authorization  
43 request within two days if the request is for medical care or other service for a condition where  
44 application of the time frame for making routine or non-life-threatening care determinations is  
45 either of the following:

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

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

51 (e) If the information submitted is considered incomplete, the health insurer shall identify  
52 all deficiencies and within two business days from the day on the electronic receipt of the prior  
53 authorization request return the prior authorization to the health care practitioner. The health care  
54 practitioner shall provide the additional information requested within three business days from the  
55 time the return request is received by the health care practitioner or the prior authorization is  
56 deemed denied and a new request must be submitted.

57 (f) If the health insurer wishes to audit the prior authorization or if the information regarding  
58 step therapy is incomplete, the prior authorization may be transferred to the peer review process.

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 appeal process shall take no  
70 longer than 30 days.

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

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

79 (k) In the event a health care practitioner has performed an average of 30 procedures per  
80 year and in a six-month time period has received a 100 percent prior approval rating, the health  
81 insurer shall not require the health care practitioner to submit a prior authorization for that  
82 procedure for the next six months. At the end of the six-month time frame, the exemption shall  
83 be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer  
84 at any time and may be rescinded if the health insurer determines the health care practitioner is  
85 not performing the procedure in conformity with the health insurer's benefit plan based upon the  
86 results of the health insurer's internal audit.

87 (l) The health insurer must accept and respond to electronically submitted prior

88 authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently  
89 accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement  
90 this provision. The health insurer shall accept and respond to prior authorizations through a secure  
91 electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

92 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
93 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
94 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
95 or after the effective date of this section.

96 (n) The timeframes in this section are not applicable to prior authorization requests  
97 submitted through telephone, mail, or fax.

**ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS, AND HEALTH SERVICE CORPORATIONS.**

**§33-24-7s. Prior authorization.**

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

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

8 “National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard” means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United  
10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the

12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from a health insurer about the  
14 coverage of a service or medication.

15 (b)The health insurer is required to develop prior authorization forms and portals and shall  
16 accept one prior authorization for an episode of care. These forms are required to be placed in  
17 an easily identifiable and accessible place on the health insurer’s webpage. The forms shall:

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

19 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
20 forms are submitted electronically;

21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
22 durable medical equipment and anything else for which the health insurer requires a prior  
23 authorization. This list shall delineate those items which are bundled together as part of the  
24 episode of care. The standard for including any matter on this list shall be science-based using  
25 a nationally recognized standard. This list is required to be updated at least quarterly to ensure  
26 that the list remains current;

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

32 (5) Be prepared by October 1, 2019.

33 (c) The health insurer shall accept electronic prior authorization requests and respond to  
34 the request through electronic means by July 1, 2020. The health insurer is required to accept an  
35 electronically submitted prior authorization and may not require more than one prior authorization  
36 form for an episode of care. If the health insurer is currently accepting electronic prior authorization  
37 requests, the health insurer shall have until January 1, 2020, to implement the provisions of this

38 section.

39 (d) If the health care practitioner submits the request for prior authorization electronically,  
40 and all of the information as required is provided, the health insurer shall respond to the prior  
41 authorization request within seven days from the day on the electronic receipt of the prior  
42 authorization request, except that the health insurer shall respond to the prior authorization  
43 request within two days if the request is for medical care or other service for a condition where  
44 application of the time frame for making routine or non-life-threatening care determinations is  
45 either of the following:

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

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

51 (e) If the information submitted is considered incomplete, the health insurer shall identify  
52 all deficiencies and within two business days from the day on the electronic receipt of the prior  
53 authorization request return the prior authorization to the health care practitioner. The health care  
54 practitioner shall provide the additional information requested within three business days from the  
55 day the return request is received by the health care practitioner or the prior authorization is  
56 deemed denied and a new request must be submitted.

57 (f) If the health insurer wishes to audit the prior authorization or if the information regarding  
58 step therapy is incomplete, the prior authorization may be transferred to the peer review process.

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 appeal process shall take no  
70 longer than 30 days.

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

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

79 (k) In the event a health care practitioner has performed an average of 30 procedures per  
80 year and in a six-month time period has received a 100 percent prior approval rating, the health  
81 insurer shall not require the health care practitioner to submit a prior authorization for that  
82 procedure for the next six months. At the end of the six-month time frame, the exemption shall  
83 be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the  
84 health insurer and may be rescinded if the health insurer determines the health care practitioner  
85 is not performing the procedure in conformity with the health insurer's benefit plan based upon  
86 the results of the health insurer's internal audit.

87 (l) The health insurer must accept and respond to electronically submitted prior  
88 authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently  
89 accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement



90 this provision. The health insurer shall accept and respond to prior authorizations through a secure  
91 electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

92 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
93 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
94 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on  
95 or after the effective date of this section.

96 (n) The timeframes in this section are not applicable to prior authorization requests  
97 submitted through telephone, mail, or fax.

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

### **§33-25-8p. Prior authorization.**

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

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

8 “National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard” means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United  
10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the  
12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from a health insurer about the  
14 coverage of a service or medication.

15 (b)The health insurer is required to develop prior authorization forms and portals and shall  
16 accept one prior authorization for an episode of care. These forms are required to be placed in

17 an easily identifiable and accessible place on the health insurer's webpage. The forms shall:

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

19 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
20 forms are submitted electronically;

21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
22 durable medical equipment and anything else for which the health insurer requires a prior  
23 authorization. This list shall delineate those items which are bundled together as part of the  
24 episode of care. The standard for including any matter on this list shall be science-based using  
25 a nationally recognized standard. This list is required to be updated at least quarterly to ensure  
26 that the list remains current;

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

32 (5) Be prepared by October 1, 2019.

33 (c) The health insurer shall accept electronic prior authorization requests and respond to  
34 the request through electronic means by July 1, 2020. The health insurer is required to accept an  
35 electronically submitted prior authorization and may not require more than one prior authorization  
36 form for an episode of care. If the health insurer is currently accepting electronic prior authorization  
37 requests, the health insurer shall have until January 1, 2020, to implement the provisions of this  
38 section.

39 (d) If the health care practitioner submits the request for prior authorization electronically,  
40 and all of the information as required is provided, the health insurer shall respond to the prior  
41 authorization request within seven days from the day on the electronic receipt of the prior  
42 authorization request, except that the health insurer shall respond to the prior authorization

43 request within two days if the request is for medical care or other service for a condition where  
44 application of the time frame for making routine or non-life-threatening care determinations is  
45 either of the following:

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

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

51 (e) If the information submitted is considered incomplete, the health insurer shall identify  
52 all deficiencies and within two business days from the day on the electronic receipt of the prior  
53 authorization request return the prior authorization to the health care practitioner. The health care  
54 practitioner shall provide the additional information requested within three business days from the  
55 day the return request is received by the health care practitioner or the prior authorization is  
56 deemed denied and a new request must be submitted.

57 (f) If the health insurer wishes to audit the prior authorization or if the information regarding  
58 step therapy is incomplete, the prior authorization may be transferred to the peer review process.

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 appeal process shall take no  
70 longer than 30 days.

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

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

79 (k) In the event a health care practitioner has performed an average of 30 procedures per  
80 year and in a six-month time period has received a 100 percent prior approval rating, the health  
81 insurer shall not require the health care practitioner to submit a prior authorization for that  
82 procedure for the next six months. At the end of the six-month time frame, the exemption shall  
83 be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the  
84 health insurer and may be rescinded if the health insurer determines the health care practitioner  
85 is not performing the procedure in conformity with the health insurer's benefit plan based upon  
86 the results of the health insurer's internal audit.

87 (l) The health insurer must accept and respond to electronically submitted prior  
88 authorization requests for pharmacy benefits by July 1, 2020, or if the health insurer is currently  
89 accepting electronic prior authorization requests, it shall have until January 1, 2020, to implement  
90 this provision. The health insurer shall accept and respond to prior authorizations through a secure  
91 electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

92 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
93 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
94 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on

95 or after the effective date of this section.

96 (n) The timeframes in this section are not applicable to prior authorization requests  
97 submitted through telephone, mail, or fax.

## **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

### **§33-25A-8s. Prior authorization.**

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

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

8 “National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard” means the  
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United  
10 States Department of Health and Human Services. Subsequently released versions may be used  
11 provided that the new version is backward compatible with the current version approved by the  
12 United States Department of Health and Human Services;

13 “Prior Authorization” means obtaining advance approval from a health maintenance  
14 organization about the coverage of a service or medication.

15 (b)The health maintenance organization is required to develop prior authorization forms  
16 and portals and shall accept one prior authorization for an episode of care. These forms are  
17 required to be placed in an easily identifiable and accessible place on the health maintenance  
18 organization’s webpage. The forms shall:

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

20 (2) Provide an electronic notification confirming receipt of the prior authorization request if  
21 forms are submitted electronically;

22 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
23 durable medical equipment and anything else for which the health maintenance organization  
24 requires a prior authorization. This list shall also delineate those items which are bundled together  
25 as part of the episode of care. The standard for including any matter on this list shall be science-  
26 based using a nationally recognized standard. This list is required to be updated at least quarterly  
27 to ensure that the list remains current;

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

33 (5) Be prepared by October 1, 2019.

34 (c) The health maintenance organization shall accept electronic prior authorization  
35 requests and respond to the request through electronic means by July 1, 2020. The health  
36 maintenance organization is required to accept an electronically submitted prior authorization and  
37 may not require more than one prior authorization form for an episode of care. If the health  
38 maintenance organization is currently accepting electronic prior authorization requests, the health  
39 maintenance organization shall have until January 1, 2020, to implement the provisions of this  
40 section.

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

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

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

53 (e) If the information submitted is considered incomplete, the health maintenance  
54 organization shall identify all deficiencies and within two business days from the day on the  
55 electronic receipt of the prior authorization request return the prior authorization to the health care  
56 practitioner. The health care practitioner shall provide the additional information requested within  
57 three business days from the day the return request is received by the health care practitioner or  
58 the prior authorization is deemed denied and a new request must be submitted.

59 (f) If the health maintenance organization wishes to audit the prior authorization or if the  
60 information regarding step therapy is incomplete, the prior authorization may be transferred to the  
61 peer review process.

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

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

67 (i) If a prior authorization is rejected by the health maintenance organization and the health  
68 care practitioner who submitted the prior authorization requests an appeal by peer review of the  
69 decision to reject, the peer review shall be with a health care practitioner similar in specialty,  
70 education, and background. The health maintenance organization's medical director has the  
71 ultimate decision regarding the appeal determination and the health care practitioner has the  
72 option to consult with the medical director after the peer-to-peer consultation. Time frames  
73 regarding this appeal process shall take no longer than 30 days.

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

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

82 (k) In the event a health care practitioner has performed an average of 30 procedures per  
83 year and in a six-month time period has received a 100 percent prior approval rating, the health  
84 maintenance organization shall not require the health care practitioner to submit a prior  
85 authorization for that procedure for the next six months. At the end of the six-month time frame,  
86 the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing,  
87 at any time, by the health maintenance organization and may be rescinded if the health  
88 maintenance organization determines the health care practitioner is not performing the procedure  
89 in conformity with the health maintenance organization's benefit plan based upon the results of  
90 the health maintenance organization's internal audit.

91 (l) The health maintenance organization must accept and respond to electronically  
92 submitted prior authorization requests for pharmacy benefits by July 1, 2020, or if the health  
93 maintenance organization are currently accepting electronic prior authorization requests, it shall  
94 have until January 1, 2020, to implement this provision. The health maintenance organizations  
95 shall accept and respond to prior authorizations through a secure electronic transmission using  
96 the NCPDP SCRIPT Standard ePA transactions.

97 (m) This section is effective for policy, contract, plans, or agreements beginning on or after  
98 January 1, 2020. This section applies to all policies, contracts, plans, or agreements, subject to  
99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on



100 or after the effective date of this section.

101 (n) The timeframes in this section are not applicable to prior authorization requests  
102 submitted through telephone, mail, or fax.

And by amending the title by inserting a new title to read as follows:

**“Eng. House Bill No. 2351**—A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §5-16-7f; to amend said code by adding thereto a new section, designated §33-15-4s; to amend said code by adding thereto a new section, designated §33-16-3dd; to amend said code by adding thereto a new section, designated §33-24-7s; to amend said code by adding thereto a new section, designated §33-25-8p; and to amend said code by adding thereto a new section, designated §33-25A-8s, all relating to prior authorizations; requiring health insurers to develop prior authorization forms; requiring health insurers to develop prior authorization portals; defining terms; providing for electronically transmitted prior authorization forms; establishing procedures for submission and acceptance of forms; establishing form requirements; establishing deadlines for approval of prior authorizations; providing for a process of an incomplete prior authorization submission; providing for an audit; setting forth peer review procedures; requiring health insurers to accept a prior authorization from other health insurers for a period of time; requiring health insurers to use certain standards when reviewing a prior authorization; providing an exemption for medication provide upon discharge; requiring an exemption for health care practitioners meeting specified criteria; requiring certain information to be included on the health insurer’s web page; establishing deadlines for pharmacy benefit prior authorization; establishing submission format for pharmacy benefits; setting forth an effective date; providing for implementation applicability; and setting deadlines.”

Respectfully submitted,

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Mike Maroney,

Chair,

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Tom Takubo

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Ron Stollings

Conferees on the part

of the Senate.

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Joe Ellington,

Chair,

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Ray Hollen

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Margaret Staggars

Conferees on the part of

the House of Delegates.