

# **WEST VIRGINIA LEGISLATURE**

## **2021 REGULAR SESSION**

**Introduced**

### **House Bill 3184**

BY DELEGATE BATES

[Introduced March 16, 2021; Referred  
to the Committee on Banking and Insurance then the  
Judiciary]

1 A BILL to amend and reenact §5-16-7f of the Code of West Virginia, 1931, as amended; to amend  
 2 and reenact §23-4-3 of said code; to amend and reenact §33-15-4s of said code; to amend  
 3 and reenact §33-16-3dd of said code; to amend and reenact §33-24-7s of said code; to  
 4 amend and reenact §33-25-8p of said code; and to amend and reenact §33-25A-8s of  
 5 said code, all relating to ensuring that sections of the code that were modified during the  
 6 2019 legislative to include workers' compensation providers in the insurance prior  
 7 authorization process.

*Be it enacted by the Legislature of West Virginia:*

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

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

**§5-16-7f. Prior authorization.**

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

3 "Episode of Care" means a specific medical problem, condition, or specific illness being  
 4 managed including tests, procedures and rehabilitation initially requested by 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 timeframe for making routine or nonlife-  
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. Timeframes  
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 timeframe, 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.* of this code.

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 timeframe,  
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.

103 (o) Workers' Compensation providers shall be included in the insurance prior authorization  
104 process.

## CHAPTER 23. WORKERS COMPENSATION.

### ARTICLE 4. DISABILITY AND DEATH BENEFITS.

**§23-4-3. Schedule of maximum disbursements for medical, surgical, dental and hospital treatment; legislative approval; guidelines; preferred provider agreements; charges in excess of scheduled amounts not to be made; required disclosure of financial interest in sale or rental of medically related mechanical appliances or devices; promulgation of rules to enforce requirement; consequences of failure to disclose; contract by employer with hospital, physician, etc., prohibited; criminal penalties for violation; payments to certain providers prohibited; medical cost and care**

**program; payments; interlocutory orders.**

1 (a) The Workers' Compensation Commission, and effective upon termination of the  
2 commission, the Insurance Commissioner, shall establish and alter from time to time, as it  
3 determines appropriate, a schedule of the maximum reasonable amounts to be paid to health  
4 care providers, providers of rehabilitation services, providers of durable medical and other goods  
5 and providers of other supplies and medically related items or other persons, firms or corporations  
6 for the rendering of treatment or services to injured employees under this chapter. The  
7 commission and effective upon termination of the commission, the Insurance Commissioner, also,  
8 on the first day of each regular session and also from time to time, as it may consider appropriate,  
9 shall submit the schedule, with any changes thereto, to the Legislature.

10 The commission, and effective upon termination of the commission, all private carriers  
11 and self-insured employers or their agents, shall disburse and pay for personal injuries to the  
12 employees who are entitled to the benefits under this chapter as follows:

13 (1) Sums for health care services, rehabilitation services, durable medical and other goods  
14 and other supplies and medically related items as may be reasonably required. The commission,  
15 and effective upon termination of the commission, all private carriers and self-insured employers  
16 or their agents, shall determine that which is reasonably required within the meaning of this  
17 section in accordance with the guidelines developed by the health care advisory panel pursuant  
18 to section three-b of this article: *Provided*, That nothing in this section shall prevent the  
19 implementation of guidelines applicable to a particular type of treatment or service or to a  
20 particular type of injury before guidelines have been developed for other types of treatment or  
21 services or injuries: *Provided, however*, That any guidelines for utilization review which are  
22 developed in addition to the guidelines provided for in section three-b of this article may be used  
23 by the commission, and effective upon termination of the commission, all private carriers and self-  
24 insured employers or their agents, until superseded by guidelines developed by the health care  
25 advisory panel pursuant to said section. Each health care provider who seeks to provide services

26 or treatment which are not within any guideline shall submit to the commission, and effective upon  
27 termination of the commission, all private carriers, self-insured employers and other payors,  
28 specific justification for the need for the additional services in the particular case and the  
29 commission shall have the justification reviewed by a health care professional before authorizing  
30 the additional services. The commission, and effective upon termination of the commission, all  
31 private carriers, self-insured employers and other payors, may enter into preferred provider and  
32 managed care agreements which provides for fees and other payments which deviate from the  
33 schedule set forth in this subsection.

34 (2) Payment for health care services, rehabilitation services, durable medical and other  
35 goods and other supplies and medically related items authorized under this subsection may be  
36 made to the injured employee or to the person, firm or corporation who or which has rendered the  
37 treatment or furnished health care services, rehabilitation services, durable medical or other  
38 goods or other supplies and items, or who has advanced payment for them, as the commission,  
39 and effective upon termination of the commission, all private carriers, self-insured employers and  
40 other payors, considers proper, but no payments or disbursements shall be made or awarded by  
41 the commission unless duly verified statements on forms prescribed by the commission, and  
42 effective upon termination of the commission, all private carriers, self-insured employers and other  
43 payors, have been filed within six months after the rendering of the treatment or the delivery of  
44 such goods, supplies or items or within 90 days of a subsequent compensability ruling if a claim  
45 is initially rejected: *Provided*, That no payment under this section shall be made unless a verified  
46 statement shows no charge for or with respect to the treatment or for or with respect to any of the  
47 items specified in this subdivision has been or will be made against the injured employee or any  
48 other person, firm or corporation. When an employee covered under the provisions of this chapter  
49 is injured, in the course of and as a result of his or her employment and is accepted for health  
50 care services, rehabilitation services, or the provision of durable medical or other goods or other  
51 supplies or medically related items, the person, firm or corporation rendering the treatment may

52 not make any charge or charges for the treatment or with respect to the treatment against the  
53 injured employee or any other person, firm or corporation which would result in a total charge for  
54 the treatment rendered in excess of the maximum amount set forth therefor in the commission  
55 schedule set forth in this subsection.

56 (3) Any pharmacist filling a prescription for medication for a workers' compensation  
57 claimant shall dispense a generic brand of the prescribed medication if a generic brand exists. If  
58 a generic brand does not exist, the pharmacist may dispense the name brand. In the event that a  
59 claimant wishes to receive the name brand medication in lieu of the generic brand, the claimant  
60 may receive the name brand medication but, in that event, the claimant is personally liable for the  
61 difference in costs between the generic brand medication and the brand name medication.

62 (4) In the event that a claimant elects to receive health care services from a health care  
63 provider from outside of the State of West Virginia and if that health care provider refuses to abide  
64 by and accept as full payment the reimbursement made by the Workers' Compensation  
65 Commission, and effective upon termination of the commission, all private carriers and self-  
66 insured employers or their agents, pursuant to the schedule of maximum reasonable amounts of  
67 fees authorized by this subsection, with the exceptions noted below, the claimant is personally  
68 liable for the difference between the scheduled fee and the amount demanded by the out-of-state  
69 health care provider.

70 (A) In the event of an emergency where there is an urgent need for immediate medical  
71 attention in order to prevent the death of a claimant or to prevent serious and permanent harm to  
72 the claimant, if the claimant receives the emergency care from an out-of-state health care provider  
73 who refuses to accept as full payment the scheduled amount, the claimant is not personally liable  
74 for the difference between the amount scheduled and the amount demanded by the health care  
75 provider. Upon the claimant's attaining a stable medical condition and being able to be transferred  
76 to either a West Virginia health care provider or an out-of-state health care provider who has  
77 agreed to accept the scheduled amount of fees as payment in full, if the claimant refuses to seek

78 the specified alternative health care providers, he or she is personally liable for the difference in  
79 costs between the scheduled amount and the amount demanded by the health care provider for  
80 services provided after attaining stability and being able to be transferred.

81 (B) In the event that there is no health care provider reasonably near to the claimant's  
82 home who is qualified to provide the claimant's needed medical services who is either located in  
83 the State of West Virginia or who has agreed to accept as payment in full the scheduled amounts  
84 of fees, the commission, upon application by the claimant, may authorize the claimant to receive  
85 medical services from another health care provider. The claimant is not personally liable for the  
86 difference in costs between the scheduled amount and the amount demanded by the health care  
87 provider.

88 (b)(1) No employer shall enter into any contracts with any hospital, its physicians, officers,  
89 agents or employees to render medical, dental or hospital service or to give medical or surgical  
90 attention to any employee for injury compensable within the purview of this chapter and no  
91 employer shall permit or require any employee to contribute, directly or indirectly, to any fund for  
92 the payment of such medical, surgical, dental or hospital service within such hospital for the  
93 compensable injury. Any employer violating this subsection is liable in damages to the employer's  
94 employees as provided in section eight, article two of this chapter, and any employer or hospital  
95 or agent or employee thereof violating the provisions of this section is guilty of a misdemeanor  
96 and, upon conviction thereof, shall be punished by a fine not less than \$100 nor more than \$1,000  
97 or by imprisonment not exceeding one year, or both.

98 (2) The provisions of this subsection shall not prohibit an employer, the successor to the  
99 commission, other private carrier or self-insured employer from participating in a managed health  
100 care plan, including, but not limited to, a preferred provider organization or program or a health  
101 maintenance organization or managed care organization or other medical cost containment  
102 relationship with the providers of medical, hospital or other health care. An employer, successor  
103 to the commission, other private carrier or self-insured employer that provides a managed health

104 care plan approved by the commission or, upon termination of the commission, the Insurance  
105 Commissioner, for its employees or the employees of its insured may require an injured employee  
106 to use health care providers authorized by the managed health care plan for care and treatment  
107 of his or her compensable injuries. If the employer does not provide a managed health care plan  
108 or program, the claimant may select his or her initial health care provider for treatment of a  
109 compensable injury or disease, except as provided under subdivision (3) of this subsection. If a  
110 claimant wishes to change his or her health care provider and if his or her employer has  
111 established and maintains a managed health care plan, the claimant shall select a new health  
112 care provider through the managed health care plan. A claimant who has used the providers  
113 under the employer's managed health care plan may select a health care provider outside the  
114 employer's plan for treatment of the compensable injury or disease if the employee receives  
115 written approval from the commission to do so and the approval is given pursuant to criteria  
116 established by rule of the commission.

117 (3) If the commission enters into an agreement which has been approved by the board of  
118 managers with a managed health care plan, including, but not limited to, a preferred provider  
119 organization or program, a health maintenance organization or managed care organization or  
120 other health care delivery organization or organizations or other medical cost containment  
121 relationship with the providers of medical, hospital or other health care, then:

122 (A) If an injured employee's employer does not provide a managed health care plan  
123 approved by the commission for its employees as described in subdivision (2) of this subsection,  
124 the commission may require the employee to use health care providers authorized by the  
125 commission's managed health care plan for care and treatment of his or her compensable injuries;  
126 and

127 (B) If a claimant seeks to change his or her initial choice of health care provider where  
128 neither the employer nor the commission had an approved health care management plan at the  
129 time the initial choice was made, and if the claimant's employer does not provide access to such

130 a plan as part of the employer's general health insurance benefit, then the claimant shall be  
131 provided with a new health care provider from the commission's managed health care plan  
132 available to him or her.

133 (c) When an injury has been reported to the commission by the employer without protest,  
134 the commission or self-insured employer may pay, within the maximum amount provided by  
135 schedule established under this section, bills for health care services without requiring the injured  
136 employee to file an application for benefits.

137 (d) The commission, successor to the commission, other private carrier or self-insured  
138 employer, whichever is applicable, shall provide for the replacement of artificial limbs, crutches,  
139 hearing aids, eyeglasses and all other mechanical appliances provided in accordance with this  
140 section which later wear out, or which later need to be refitted because of the progression of the  
141 injury which caused the devices to be originally furnished, or which are broken in the course of  
142 and as a result of the employee's employment. The commission, successor to the commission,  
143 other private carrier or self-insured employer shall pay for these devices, when needed,  
144 notwithstanding any time limits provided by law.

145 (e) No payment shall be made to a health care provider who is suspended or terminated  
146 under the terms of section three-c of this article except as provided in subsection (c) of said  
147 section.

148 (f) The commission, successor to the commission, other private carrier or self-insured  
149 employer, whichever is applicable, may engage in and contract for medical cost containment  
150 programs, pharmacy benefits management programs, medical case management programs and  
151 utilization review programs. Payments for these programs shall be made from the Workers'  
152 Compensation Fund or the funds of the successor to the commission, other private carrier, or self-  
153 insured employer. Any order issued pursuant to the program shall be interlocutory in nature until  
154 an objecting party has exhausted all review processes provided for by the commission, successor  
155 to the commission, other private carrier or self-insured employer, whichever is applicable.

156 (g) Notwithstanding the provisions of this section, the commission, successor to the  
 157 commission, other private carrier or self-insured employer may establish fee schedules, make  
 158 payments and take other actions required or allowed pursuant to §16-29D-1 et seq. of this code.

159 (h) Workers' Compensation providers shall be included in the insurance prior authorization  
 160 process.

## 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 a  
25 nationally recognized standard. This list is required to be updated at least quarterly to ensure that  
26 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 timeframe for making routine or nonlife-threatening care determinations is either  
45 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. Timeframes regarding this appeal process shall take no longer

70 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 timeframe, 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.* of this code.

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 timeframe, the exemption shall be  
83 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health  
84 insurer and may be rescinded if the health insurer determines the health care practitioner is not  
85 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  
91 secure 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.

98 (o) Workers' Compensation providers shall be included in the insurance prior authorization  
99 process.

## **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 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.

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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:

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21 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,  
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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 a  
25 nationally recognized standard. This list is required to be updated at least quarterly to ensure that  
26 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 timeframe for making routine or nonlife-threatening care determinations is either  
45 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. Timeframes regarding this appeal process shall take no longer  
70 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 timeframe, 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.* of this code.

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 timeframe, the exemption shall be  
83 reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at  
84 any time and may be rescinded if the health insurer determines the health care practitioner is not  
85 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  
91 secure 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.

98

99 (o) Workers' Compensation providers shall be included in the insurance prior authorization  
100 process.

**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 a  
25 nationally recognized standard. This list is required to be updated at least quarterly to ensure that  
26 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 timeframe for making routine or nonlife-threatening care determinations is either  
45 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. Timeframes regarding this appeal process shall take no longer  
70 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 timeframe, 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.* of this code.

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 timeframe, the exemption shall be  
83 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health  
84 insurer and may be rescinded if the health insurer determines the health care practitioner is not  
85 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  
91 secure 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.

98           (o) Workers' compensation providers shall be included in the insurance prior authorization  
99 process.

## **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 a  
25 nationally recognized standard. This list is required to be updated at least quarterly to ensure that  
26 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 timeframe for making routine or nonlife-threatening care determinations is either  
45 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. Timeframes regarding this appeal process shall take no longer  
70 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 timeframe, 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.* of this code.

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 timeframe, the exemption shall be  
83 reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the health  
84 insurer and may be rescinded if the health insurer determines the health care practitioner is not  
85 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  
91 secure 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.

98 (o) Workers' compensation providers shall be included in the insurance prior authorization  
99 process.

## **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 patient  
30 has completed step therapy as required by the health maintenance organization 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 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 timeframe for making routine or nonlife-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. Timeframes  
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 timeframe, 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.* of this code.

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 timeframe,  
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.

103 (o) Workers' Compensation providers shall be included in the insurance prior authorization

104 process.

NOTE: The purpose of this bill is to include Workers' compensation providers into the insurance prior authorization process.

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