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]

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

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

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

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

(c) The Public Employees Insurance Agency shall accept electronic prior authorization requests and respond to the request through electronic means by July 1, 2020. The Public Employees Insurance Agency is required to accept an electronically submitted prior authorization

and may not require more than one prior authorization form for an episode of care. If the Public Employees Insurance Agency is currently accepting electronic prior authorization requests, the Public Employees Insurance Agency shall have until January 1, 2020, to implement the provisions of this section.

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

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

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

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

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

(g) A prior authorization approved by the Public Employees Insurance Agency is carried

over to all other managed care organizations and health insurers for three months, if the services are provided within the state.

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

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

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

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

(k) In the event a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 100 percent prior approval rating, the Public Employees Insurance Agency shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month timeframe, the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency and may be rescinded if the Public Employees Insurance Agency determines the health care practitioner is not performing the

procedure in conformity with the Public Employees Insurance Agency's benefit plan based upon the results of the Public Employees Insurance Agency's internal audit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s. Prior authorization.

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within seven days from the day on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where

application of the timeframe for making routine or nonlife-threatening care determinations is either of the following:

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

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

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

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

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

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

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Timeframes regarding this appeal process shall take no longer

than 30 days.

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

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

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

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

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

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

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

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

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

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

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

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

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

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

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

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

(5) Be prepared by October 1, 2019.

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

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

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the

patient's psychological state; or

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

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

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

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

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

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

(j)(1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization shall not be subject to prior authorization requirements and shall be immediately

approved for not less than three days: *Provided,* That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day timeframe, a prior authorization must be obtained.

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

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

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

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

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

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

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

§33-24-7s. Prior authorization.

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

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

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

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

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

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

(2) Provide an electronic notification confirming receipt of the prior authorization request if

forms are submitted electronically;

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

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

(5) Be prepared by October 1, 2019.

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

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

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

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

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

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

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

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

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

(j)(1) Any prescription written for an inpatient at the time of discharge requiring a prior

authorization shall not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day timeframe, a prior authorization must be obtained.

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

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

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

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

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

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

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p. Prior authorization.

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

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

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

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

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

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

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

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment and anything else for which the health insurer requires a prior

authorization. This list shall delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated at least quarterly to ensure that the list remains current;

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

(5) Be prepared by October 1, 2019.

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

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

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

(2) In the opinion of a health care practitioner with knowledge of the patient’s medical

condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

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

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

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

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

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner similar in specialty, education, and background. The health insurer’s medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Timeframes regarding this appeal process shall take no longer than 30 days.

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

prescription is being provided at discharge. After the three-day timeframe, a prior authorization must be obtained.

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

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

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

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

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

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

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s. Prior authorization.

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

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

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

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

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

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

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

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment and anything else for which the health maintenance organization requires a prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-

based using a nationally recognized standard. This list is required to be updated at least quarterly to ensure that the list remains current;

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

(5) Be prepared by October 1, 2019.

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

(d) If the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health maintenance organization shall respond to the prior authorization request within seven days from the day on the electronic receipt of the prior authorization request, except that the health maintenance organization shall respond to the prior authorization request within two days if the request is for medical care or other service for a condition where application of the timeframe for making routine or nonlife-threatening care determinations is either of the following:

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

(2) In the opinion of a health care practitioner with knowledge of the patient’s medical condition, would subject the patient to adverse health consequences without the care or treatment

that is the subject of the request.

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

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

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

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

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

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

prescription is being provided at discharge. After the three-day timeframe, a prior authorization must be obtained.

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

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

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

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

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

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

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.