WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Introduced

House Bill 2535

By Delegates Summers, Tully, Forsht, and Petitto

[Introduced January 13, 2023; Referred to the

Committee on Health and Human Resources]

A BILL to amend and reenact §5-16-7f of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §9-5-31; 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 prior authorizations; defining terms; requiring prior authorizations and relating communications to be submitted via an electronic portal; requiring electronic notification to the health care provider and insured confirming receipt of the prior authorization; establishing timelines for compliance; providing communication via the portal regarding the current status of the prior authorization; reducing timeframes for prior authorization requests; providing a timeframe for a decision to be rendered after the receipt of additional information; providing a timeframe for a claim to be submitted to audit or if the step therapy is incomplete; requiring a provider conducting peer review to be licensed in West Virginia; revising the percentage approval for a health care provider to be considered for an exemption from prior authorization criteria; removing criteria related to electronic submission of pharmacy benefits; amending effective date; requiring oversight and data collection by the Office of the Insurance Commissioner and the Inspector General; providing for civil penalties.

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~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall ~~develop~~ require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are required to~~ The portal shall be placed in an easily identifiable and accessible place on the Public Employees Insurance Agency's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

(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~~ provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(d) ~~If the~~ After 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~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

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

(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, licensed in West

Virginia, 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. Time frames regarding this appeal process shall take no longer than ~~30~~ three days.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization ~~shall~~ may be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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~~ If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a ~~100~~ 90 percent prior approval rating, the Public Employees Insurance Agency ~~shall~~ may 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 time frame, 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)~~ (l)This section is effective for policy, contract, plans, or agreements beginning on or after ~~January 1, 2020~~ January 1, 2024. 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)~~(m) The timeframes in this section are not applicable to prior authorization requests submitted through telephone, mail, or fax.

(n) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

(o) The Insurance Commissioner may assess a civil penalty for a violation of this article.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-31. 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 all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the

NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior Authorization" means obtaining advance approval from the Bureau of Medical Services about the coverage of a service or medication.

(b) The Bureau of Medical Services shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Bureau of Medical Services' webpage. The portal shall:

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

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

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the Bureau of Medical Services requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the Bureau of Medical Services 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 Bureau of Medical Services and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by October 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

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

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

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

(e) If the information submitted is considered incomplete, the Bureau of Medical Services shall identify all deficiencies and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The Bureau of Medical Services shall render a decision within two business day after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information the prior authorization is considered denied and a new request must be submitted.

(f) If the Bureau of Medical Services wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process, within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Bureau of Medical Services is carried over to all

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

(h) The Bureau of Medical Services shall use national best practice guidelines to evaluate a prior authorization.

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

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a 90 percent prior approval rating, the Bureau of Medical Services may 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 time frame, the exemption shall be reviewed prior to renewal. This exemption is subject to internal auditing, at any time, by the Bureau of Medical Services and may be rescinded if the Bureau of Medical Services determines the health care practitioner is not performing the procedure in conformity with the Bureau of Medical

Services' benefit plan based upon the results of the Bureau of Medical Services' internal audit.

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

(m) The Inspector General shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

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~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or

specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are required to~~ The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

(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~~ Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(d) ~~If~~ After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within ~~seven~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

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

decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information ~~or~~ the prior authorization is ~~deemed~~ considered 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, within two business days from the day on the electronic receipt of the prior authorization request.

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

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

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

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization ~~shall~~ may be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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~~ 90 percent prior approval rating, the health insurer ~~shall~~ may 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 time frame, 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)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or after ~~January 1, 2020~~ January 1, 2024. 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~~

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

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 the health care practitioner, to be performed at the site of service, excluding out of network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are required to~~ The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

(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~~ Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(d) ~~If~~ After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within ~~seven~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

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

(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, licensed in West Virginia, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to- peer consultation. Time frames regarding this appeal process shall take no longer than ~~30~~ three days.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization ~~shall~~ may be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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~~ 90 percent prior approval rating, the health insurer ~~shall~~ may 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 time frame, 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)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or after ~~January 1, 2020~~ January 1, 2024. 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~~

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

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~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. ~~These forms are required to~~ The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

~~(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~~ Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(c) ~~If~~ After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within ~~seven~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

(d) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies and within two business days from the day on the electronic receipt of the prior

authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information ~~or~~ the prior authorization is ~~deemed~~ considered denied and a new request must be submitted.

(e) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process, within two business days from the day on the electronic receipt of the prior authorization request.

(f) 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.

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

(h) 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, licensed in West Virginia, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this appeal process shall take no longer than ~~30~~ three days.

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

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*.

(j) ~~In the event~~ If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a ~~100~~ 90 percent prior approval rating, the health insurer ~~shall~~ may 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 time frame, 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)~~(k) This section is effective for policy, contract, plans, or agreements beginning on or after ~~January 1, 2020~~ January 1, 2024. 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.~~

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

care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

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~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an

electronic portal and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on the health insurer's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

(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~~ Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(d) ~~If~~ After the health care practitioner submits the request for prior authorization

electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within ~~seven~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

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

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

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

authorization.

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

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization ~~shall~~ may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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~~ If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a ~~100~~ 90 percent prior approval rating, the health insurer ~~shall~~ may 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 time frame, 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)~~ (l) This section is effective for policy, contract, plans, or agreements beginning on or after ~~January 1, 2020~~ January 1, 2024. 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~~

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

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~~ means all diagnostically related testing, procedures, and rehabilitation determined by the treating health care practitioner to be medically necessary to treat a specific medical problem, condition, or specific illness to be performed at the site of service, excluding out of network care.

"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~~ shall require ~~prior authorization forms and portals~~ prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. These forms are required to be placed in an easily identifiable and accessible place on the health maintenance organization's webpage. The ~~forms~~ portal shall:

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

(2) Provide an electronic notification to the health care provider and the insured confirming receipt of the prior authorization request ~~if~~ for 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~~ 2024.

(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~~ Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider and the insured.

(d) ~~If~~ After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health maintenance organization shall respond to the prior authorization request within ~~seven~~ two 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~~ a day if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

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

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

(e) If the information submitted is considered incomplete, the health maintenance

organization shall identify all deficiencies and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit the additional information ~~or~~ the prior authorization is ~~deemed~~ considered 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, within two business days from the day on the electronic receipt of the prior authorization request.

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

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

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

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

immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization 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~~ If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period has received a ~~100~~ 90 percent prior approval rating, the health maintenance organization ~~shall~~ may 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 time frame, 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)~~ (l) ~~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~~

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician denied gold card status, and the reason for such denial.

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

NOTE: The purpose of this bill is to update the law regarding prior authorizations. Provide a new definition regarding an episode of care, require the electronic submission of prior authorizations and related communications; include timeframes to streamline the prior authorization process during the process and the appeal process, provide for oversight and enforcement.

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