WEST VIRGINIA CODE: §33-15-4S

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

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

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

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

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

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

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

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

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information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

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

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

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

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

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

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

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

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

(i) If a prior authorization is rejected by the health insurer and the health care practitioner

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

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

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

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health insurer's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

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

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

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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, and the name of each physician whose gold card status was revoked and the reason for revocation.

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

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