

WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

OFFICE WEST VIRGINIA
SECRETARY OF STATE

2019 MAR - 1 P 4: 52

FILED

ENROLLED

House Bill 2351

BY DELEGATES ELLINGTON, HILL, ROHRBACH, ROWAN,
SUMMERS, C. THOMPSON, WALKER, STAGGERS,
ATKINSON AND ANGELUCCI

[Passed February 20, 2019; in effect from passage.]

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[Passed February 20, 2019; in effect from passage.]

1 AN ACT to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
2 designated §5-16-7f; to amend said code by adding thereto a new section, designated
3 §33-15-4s; to amend said code by adding thereto a new section, designated §33-16-3dd;
4 to amend said code by adding thereto a new section, designated §33-24-7s; to amend
5 said code by adding thereto a new section, designated §33-25-8p; and to amend said
6 code by adding thereto a new section, designated §33-25A-8s, all relating to prior
7 authorizations; requiring health insurers to develop prior authorization forms; requiring
8 health insurers to develop prior authorization portals; defining terms; providing for
9 electronically transmitted prior authorization forms; establishing procedures for
10 submission and acceptance of forms; establishing form requirements; establishing
11 deadlines for approval of prior authorizations; providing for a process of an incomplete
12 prior authorization submission; providing for an audit; setting forth peer review procedures;
13 requiring health insurers to accept a prior authorization from other health insurers for a
14 period of time; requiring health insurers to use certain standards when reviewing a prior
15 authorization; providing an exemption for medication provide upon discharge; requiring an
16 exemption for health care practitioners meeting specified criteria; requiring certain
17 information to be included on the health insurer's web page; establishing deadlines for
18 pharmacy benefit prior authorization; establishing submission format for pharmacy
19 benefits; setting forth an effective date; providing for implementation applicability; and
20 setting deadlines.

Be it enacted by the Legislature of West Virginia:

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

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

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

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

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

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

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

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

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

22 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
23 durable medical equipment, and anything else for which the Public Employees Insurance Agency
24 requires a prior authorization. This list shall delineate those items which are bundled together as

25 part of the episode of care. The standard for including any matter on this list shall be science-
26 based using a nationally recognized standard. This list is required to be updated at least quarterly
27 to ensure that the list remains current;

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

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

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

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

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

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

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

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

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

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

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

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

76 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
77 \$5,000 per day and the health care practitioner shall note on the prescription or notify the
78 pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
79 prior authorization must be obtained.

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

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

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

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

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

CHAPTER 33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s. Prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

59 (g) A prior authorization approved by a managed care organization is carried over to health
60 insurers, the public employees insurance agency and all other managed care organizations for
61 three months if the services are provided within the state.

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

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

71 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
72 authorization shall not be subject to prior authorization requirements and shall be immediately
73 approved for not less than three days: *Provided*, That the cost of the medication does not exceed

74 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
75 prescription is being provided at discharge. After the three-day time frame, a prior authorization
76 must be obtained.

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

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

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

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

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

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

§33-24-7s. Prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p. Prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

71 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
72 authorization shall not be subject to prior authorization requirements and shall be immediately
73 approved for not less than three days: *Provided*, That the cost of the medication does not exceed

74 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
75 prescription is being provided at discharge. After the three-day time frame, a prior authorization
76 must be obtained.

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

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

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

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

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

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s. Prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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78 prescription is being provided at discharge. After the three-day time frame, a prior authorization
79 must be obtained.

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

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

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

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

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

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Noel Capito
.....
Chairman, House Committee

Mark Jayne
.....
Chairman, Senate Committee

Originating in the House.

In effect from passage.

Steph D. Harris
.....
Clerk of the House of Delegates

Joe Annunzio
.....
Clerk of the Senate

Ray Henshaw
.....
Speaker of the House of Delegates

W. B. Combs
.....
President of the Senate

OFFICE WEST VIRGINIA
SECRETARY OF STATE

2019 MAR - 1 P 4: 53

FILED

The within *is* approved this the *first*
day of *March* 2019.

James Justice
.....
Governor

PRESENTED TO THE GOVERNOR

FEB 26 2019

Time 1:51 pm