WEST VIRGINIA INSURANCE BULLETIN
No. 24 – 03a

Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► Prior Authorizations ◄

On September 16, 2021, the Offices of the Insurance Commissioner ("OIC") issued Insurance Bulletin No. 21-08 regarding electronic prior authorizations and House Bill 2351 (2019). In 2023, the West Virginia Legislature passed Senate Bill 267 (2023), which updated and amended certain provisions of the 2019 law. The OIC is issuing Insurance Bulletin No. 24-03 to incorporate the new provisions of Senate Bill 267 (2023). Insurance Bulletin No. 21-08, while historically accurate, is hereby rescinded and replaced with Insurance Bulletin No. 24-03.

In 2019 and 2023, the West Virginia Legislature passed legislation regarding prior authorizations, generally codified at W.Va. Code §§ 33-15-4s, 33-16-3dd, 33-24-7s, 33-25-8p, and 33-25A-8s (collectively referred to herein as the "prior authorization law").[1] Taken as a whole, the prior authorization law is intended to:

- Require prior authorizations and related communications to be submitted via an electronic portal;
- Reduce administrative burdens for health care practitioners in regard to electronic prior authorizations by bundling items together as part of an "episode of care";
- Reward health care practitioners who meet high standards for frequency, performance, and approval with a "gold card" exemption;
- Enhance timely patient care by reducing patient delays in obtaining necessary medical care; and
- Provide for appropriate and continued oversight by health insurers by requiring that health insurers and PEIA report data quarterly to the OIC and providing for assessment of a civil penalty against a health insurer or PEIA for a violation of the prior authorization law.

Prior Authorizations Generally; Electronic Submissions Mandated

The prior authorization law provides that:

- Effective July 1, 2024, a 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."

[1] In regard to the Public Employees' Insurance Agency (PEIA), House Bill 2351's provisions were also codified at W.Va. Code § 5-16-7f. Additionally, Senate Bill 267 (2023) implemented prior authorization requirements concerning health care coverage provided by the Bureau of Medical Services (Medicaid). However, this Insurance Bulletin does not address PEIA or Medicaid, specifically.

- **A health insurer shall accept one prior authorization request per "episode of care."** An "episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by a health care practitioner, to be performed at the site of service, excluding out of network care. However, any additional testing or procedure related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.
- A health insurer's electronic 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.
- A health insurer's electronic portal shall include instructions for the submission of clinical documentation.
- A health insurer's electronic portal shall provide electronic notification confirming receipt of the prior authorization request if the forms are submitted electronically.
- A health insurer's electronic portal shall contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires prior authorization requests and must specifically delineate items which are bundled together as an "episode of care." The requirement for including any matter on this list must be science-based using a nationally recognized standard, and the list must be updated at least quarterly to ensure that the list remains current.
- A health insurer's electronic portal shall conspicuously inform the patient and health care practitioner if the health insurer requires the use of step therapy protocols. If such protocols are required by the health insurer, the prior authorization form shall clearly provide an opportunity for the health care practitioner to report that the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful. The health care practitioner should include sufficient information regarding specific medication or therapies that were attempted.

The prior authorization law explicitly provides that an electronic notification confirming receipt of the prior authorization request must be provided by the health insurer to the health care practitioner. For this electronic notification or confirmation to be useful, the OIC has determined that it should provide a unique identification code or tracking number that the health care practitioner can use to check on the status of an electronic prior authorization request.

Prior Authorization Review Timeline

The prior authorization law also sets forth strict timelines for health insurers to review prior authorization requests. Timelines for prior authorization review were updated in Senate Bill 267 (2023) and became effective for all policy, contracts, plans, or agreements delivered, executed, issued, amended, adjuster or renewed in West Virginia on or after January 1, 2024. The timelines for review are as follows:

- For complete prior authorization requests submitted to a health insurer for non-life-threatening or routine medical care, the health insurer must respond to the request within **five (5) business days** from the date on the electronic receipt of the prior authorization request.
- For complete prior authorization requests submitted to a health insurer for life-threatening or non-routine medical care, and wherein application of the five (5) day timeframe could seriously jeopardize the life, health, or safety of the patient, or others due to the patient's psychological state, or, in the opinion of the health care practitioner with knowledge of the patient's medical condition, subject the patient to adverse health consequences without the care or treatment subject to the request, the health insurer shall respond to the request within **two (2) business days** from the date on the electronic receipt of the prior authorization request.
- If the prior authorization request is incomplete, the health insurer must identify all deficiencies within **two (2) business days** from the date on the electronic request and return the prior authorization request to the health care practitioner. The health care practitioner shall provide the additional information

requested within **three (3) business days** from the time the returned request is received by the health care practitioner. The health insurer shall render a decision within **two (2) business days** after receipt of the additional information submitted by the health care practitioner. If the completed prior authorization is not returned to the health insurer, the prior authorization request is deemed denied and a new request must be submitted.

To be beneficial, the OIC believes that an approved prior authorization request must generate an electronic confirmation that the health care practitioner can save or download to a patient's file or electronic medical record, or print, fax, or email to a health care facility that requests or requires a copy of the approval. The approval must also contain a confirmation number or tracking number that can be used by the health care practitioner or health care facility to confirm the approval, if necessary. Once an approval is provided by the health insurer, the health care practitioner should not be required to subsequently verify the approval unless the covered individual's medical condition has substantially changed, or a significant amount of time has passed since the prior authorization was approved. As noted below, the prior authorization law requires a three-month carryover for prior authorizations if the approved services are provided within the state.

Peer-To-Peer Reviews and Appeals

If a prior authorization is rejected by a health insurer and the health care practitioner who submitted the electronic prior authorization request asks for 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 who submitted the prior authorization request has the option to consult with the Medical Director after the peer-to-peer consultation.

Time frame regarding the peer-to-peer appeal process shall take no longer than **five (5) business days** from the date of request of the peer-to-peer consultation.

Time frames regarding the appeal of a decision on a prior authorization shall take no longer than **ten (10) business days** from the date of the appeal submission.

Gold Card Prior Authorization Exemption Program

The "gold card" program allows a health care practitioner to earn an exemption from prior authorization requirements based upon the practitioner's track record of previous prior authorization approvals and the frequency with which the practitioner performs the procedure. If a health care practitioner has performed an average of **thirty (30) procedures per year,** and in a six-month time has received a **90% final prior approval rating**, the health insurer may not require prior authorizations for at least the next six-month period, or longer if the insurer allows.

The OIC has received questions concerning whether an insurer can require a health care practitioner to track his or her own prior authorization data and apply to the health insurer for the "gold card" exemption or whether the insurer is required to track prior authorization data and enact the "gold card" exemption automatically. However, because the prior authorization law specifically states that a health insurer **may not require** a health care practitioner to submit a prior authorization for a specific procedure once the health care practitioner meets the terms of the "gold card" program, the OIC believes the clear Legislative intent of the law is for the "gold card" exemption to be applied automatically. Accordingly, health insurers shall monitor prior authorization data to determine when/if a health care practitioner must be provided with a "gold card" exemption. When a health care practitioner qualifies, the "gold card" exemption is to be given automatically by the health insurer and the health insurer should notify the health care practitioner that he or she qualifies for the program. If a health care practitioner wants to be exempted from the program, for whatever reason, the health care

practitioner should notify the health insurer of his or her decision to opt out since the terms of the program are, statutorily, to be applied automatically.

At the end of the six-month "gold card" period, 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.

Importantly, a "gold card" exemption is subject to internal auditing at any time by the health insurer and may be rescinded if the health insurer determines that the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, the health insurer identifies substantial variances in historical utilization, or identifies anomalies based upon the results of the health insurer's internal audit. If a "gold card" exemption is revoked, the health insurer shall provide the health care practitioner with a letter detailing the rationale for revocation.

Finally, nothing in the "gold card" program shall be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, or any out-of-network service or procedure.

Prior Authorization Pharmacy Prohibitions at Inpatient Discharge

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 (3) days, **provided that the medication does not exceed $5,000 per day.** The physician prescribing the medication shall note on the prescription that it is being provided at discharge or otherwise notify the pharmacy that the prescription is being provided at discharge. After the three-day timeframe, prior authorization shall be obtained.

If approval of a prior authorization requires a medication substitution, the substituted medication shall be filled as required by *W.Va. Code* § 30-5-1 *et seq.*, known as *The Larry W. Border Pharmacy Practice Act.*

Other Important Provisions

The prior authorization law has various other important provisions. Those provisions include:

- A prior authorization that has been approved by a health insurer is carried over to all other managed care organizations, health insurers, and to PEIA for three (3) months after it is has been approved if the approved services are provided within the state.
- A health insurer is required to use national best practice guidelines to evaluate a prior authorization request.
- If a health insurer wishes to audit a prior authorization or if information regarding step therapy is incomplete, the prior authorization may be transferred to a peer review process within two (2) business days from the day on the electronic receipt of the prior authorization request.
- The OIC shall request data on a quarterly basis, or more often as needed, to oversee compliance with the prior authorization law. 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, and the name of each physician whose gold card status was revoked and the reason for revocation.
- The OIC may assess a civil penalty for violation of the prior authorization law.

A health insurer's prior authorization forms and electronic portal should be easy to use, accessible, and comprehensive. Electronic prior authorizations should be compliant with the Health Insurance Portability

and Accountability Act of 1996 ("HIPAA") and should improve communication between a health care practitioner and health insurer. When prior authorizations are submitted electronically, it should be relatively easy for a health care practitioner to track approvals, rejections, and requests for more information in "real time." This transparency should allow health care practitioners to take any necessary steps to move the prior authorization through the process. Although not mandated in the prior authorization law, the OIC encourages the availability of "real time" prior authorization approvals for appropriate procedures, services, drugs, devices, and equipment. "Real time" approvals can further ease administrative burden and decrease patient wait times.

Please e-mail questions concerning this Insurance Bulletin to OICBulletins@wv.gov or call (304) 558-0401.

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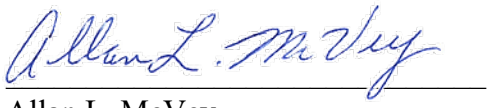

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