



## WEST VIRGINIA INSURANCE BULLETIN No. 21 - 08

*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.*

### ► **Electronic Prior Authorizations** ◀

In 2019, the West Virginia Legislature passed House Bill 2351 regarding electronic prior authorizations, which is 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”).<sup>1</sup> The prior authorization law applies to all policies, contracts, plans, or agreements that were delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of the law, which was February 20, 2019. Taken as a whole, the prior authorization law is intended to:

- Promote and encourage the use of electronic prior authorizations among health care practitioners and health insurers;
- 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 limited “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.

### **Electronic Prior Authorization Forms**

The prior authorization law’s provisions required a health insurer to accept electronic prior authorization requests by July 1, 2020. However, if a health insurer was already accepting electronic prior authorization requests at the time of the law’s effective date, then the health insurer was required to accept electronic prior authorizations on or after January 1, 2020. Additionally, the prior authorization law provides that:

- A health insurer is required to develop prior authorization forms and portals.
- 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

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<sup>1</sup> In regard to the Public Employees’ Insurance Agency (PEIA), House Bill 2351’s provisions were also codified at *W.Va. Code* § 5-16-7f. However, because the Insurance Commissioner does not regulate PEIA, this Insurance Bulletin focuses only on commercial health insurers, Hospital Medical and Dental Corporations, Health Care Corporations, and Health Maintenance Organizations (HMOs).

or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

- A health insurer shall place prior authorization request forms in an easily identifiable and accessible place on the insurer's webpage.
- A health insurer's prior authorization request forms shall include instructions for the submission of clinical documentation.
- A health insurer's prior authorization request forms shall provide electronic notification confirming receipt of the prior authorization request if the forms are submitted electronically.
- A health insurer's prior authorization request forms 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.
- A health insurer's prior authorization request forms 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 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 Insurance Commissioner 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.

### **Electronic Prior Authorization Timeline**

The prior authorization law also sets forth strict timelines for health insurers to review electronic prior authorization requests. However, these timelines are not applicable to prior authorization requests submitted through telephone, fax, or mail. The timelines for review are as follows:

- For complete prior authorization requests submitted to a health insurer electronically for non-life-threatening or routine medical care, the health insurer must respond to the request within **seven days** from the date on the electronic receipt of the prior authorization request.
- For complete prior authorization requests submitted to a health insurer electronically for life-threatening or non-routine medical care, and wherein application of the seven 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 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 in the request within **two 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, requested information to render the prior authorization request complete within **three business days** from the time the returned request is received 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. While the prior authorization law is silent in regard to how long a health insurer has to review a completed electronic prior authorization request

that has been returned to the health insurer after a health care practitioner has corrected the initial deficiencies, the Insurance Commissioner believes that the intent of the law is for the health insurer to complete their review within **two additional business days** from the time the completed request is received by the health insurer so the total review is still completed within the seven-day timeframe as set forth above.

In summary, the prior authorization law explicitly provides that an insurer shall respond to an electronic prior authorization request within two days or seven days, depending upon the circumstance. Again, in order to be useful, the Insurance Commissioner has determined that an approved electronic 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 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 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. Health insurers should honor a prior authorization for, at least, 90 days, which, as noted below, corresponds with another provision in the prior authorization law that requires a three-month carryover for prior authorizations if the approved services are provided within the state.

### Appeals

If an electronic 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 health insurer's denial, *the health insurer shall ensure that the peer review is from a health care practitioner who is similar in specialty, education, and background to the health care practitioner* who submitted the denied electronic prior authorization request. However, the health insurer's Medical Director can make the ultimate decision regarding the appeal determination, provided that the health care practitioner who submitted the electronic prior authorization request is able to consult with the health insurer's Medical Director after the peer-to-peer consultation, if requested.

The appeal process set forth herein shall take no longer than **30 days**.

### Gold Card 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 30 procedures per year, and in a six-month time period has received a 100% prior approval rating, the health insurer shall not require prior authorizations for that procedure for the next six-month period.

The Insurance Commissioner understands that some health insurers are requiring health care practitioners to track their own prior authorization data and apply to the health insurer for the "gold card" exemption when/if the practitioner qualifies, while other health insurers are tracking prior authorization data and applying the "gold card" exemption automatically. However, because the prior authorization law specifically states that a health insurer *shall 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 program, it is clear that the Legislature intended 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 due to having performed an average of 30 procedures per year, with a 100% approval rating for prior authorizations requests for that particular procedure in a six-month time frame, 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. Some health insurers allow a health care practitioner to opt out of the “gold card” exemption 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 exemption period, the insurer shall review the health care practitioner’s exemption prior to any subsequent renewal. 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 the procedure in conformity with the health insurer’s benefit plan based upon the results of the health insurer’s audit.

### **Pharmacy Benefits; Prohibitions at Inpatient Discharge**

The prior authorization law’s provisions regarding electronic prior authorization forms require a health insurer to accept electronic prior authorization requests for pharmacy benefits by July 1, 2020, or January 1, 2020, if a health insurer was already accepting electronic prior authorization requests for pharmacy benefits at the time of the law’s effective date. A health insurer must accept and respond to prior authorization requests for pharmacy benefits through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions.

A health insurer is prohibited from requiring a prior authorization for any prescription written for an inpatient at the time of discharge and such a prescription shall immediately be approved for *not less than three days*, provided that the cost of the medication does not exceed \$5,000.00 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. A health insurer can require a prior authorization after the three-day time period from discharge has expired.

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 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.

A health insurer’s prior authorization forms and 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 Insurance Commissioner strongly 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. Furthermore, paper authorization forms often result in missing, inaccurate, or incomplete information that leads to administrative rework, telephone calls and/or faxes back and forth between health care practitioners and health insurers. With electronic prior authorization tools, especially real time electronic prior authorizations, health care practitioners can prospectively complete a prior authorization request with prepopulated questions and response options based on a combination of the patient's medical condition and the patient's insurance coverage, resulting in more available time for direct patient care.

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

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