2024 Prior Authorization (PA) State Law Chart

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
AL Ala. Code 1975 § 27-3A-5		2 business days of receipt of request and all necessary info received. Plan must complete the adjudication of appeals in 30 days.							On appeal, all decisions must be made by physician in the same or similar general specialty as typically manages condition, procedure, or treatment.		When initial decision not to approve is made prior to/during an ongoing service requiring review, and physician believes warrants immediate appeal, can appeal via phone on expedited basis (48 hours).
AK 7 AAC 120.410 and Alaska Stat. § 21.07.020		Nonemergency:72 hours. For care following emergency services: 24 hours. Appeals:18 working days after received. Expedited:72 hours.		PA for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless PA is based on materially incomplete or inaccurate information.					Decisions to deny, reduce, or terminate a benefit or deny payment for service based on medically necessity must be made by employee or agent of plan who is a licensed health care provider. On appeal, same professional license as provider.		

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AR AR Code § 23-99-11 HB 1271 (2023)	Plan must strive to implement no later than July 1, 2018, mechanism by which providers may request PA through an automated electronic system as an alternative to telephone-based PA systems.	Nonurgent: 2 business days of obtaining all necessary info Urgent: 1 business day Emergency: a minimum of 24 hours following provision of emergency care for patient or provider to notify plan of admission or provision of care If occurs on holiday or weekend, plan cannot require notification until the next business day. If patient receives emergency care that requires immediate post-evaluation or post-stabilization service, a plan must make an authorization within 60 minutes of receiving a request.	Plan must pay for care that received PA for at least 90 days after PA granted unless never performed, claim was not timely, patient not eligible, fraud or misrepresentation	Cannot rescind, limit, condition based on medical necessity unless provider notified 3 business days before scheduled date. May rescind, limit, condition, or restrict PA based on eligibility at time of care if plan provided means to confirm whether patient is eligible up to the date of admission, service, procedure, or extension of stay.	Statistics must be available regarding PA approvals and denials on plan's website in a readily accessible format. Statistics must categorize approvals and denials by physician specialty; medication or diagnostic test or procedure; medical indication offered as justification for the PA request; and reason for denial.	Plans must disclose all PA requirements and any written clinical criteria, in a publicly accessible manner on website. Adverse determination must be based on medical necessity or appropriateness of services and on written clinical criteria. "Medical necessity" includes "medical appropriateness," "primary coverage criteria," & any other terminology used by plan that refers to a "primary coverage criteria," and any other terminology used by plan that refers to a determination that is based in whole/in part on clinical justification for a service.	Cannot implement new/amended requirements before providing written 60-day notice.	A provider may submit a benefit inquiry to plan for service not yet provided to determine if service meets medical necessity/other requirements for payment PA decision must include determination as to whether patient is covered by a plan and eligible to receive the requested service.	Adverse determination must be made by a physician who possesses a current and unrestricted AR license. Physician may request that PA be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by pharmacologist.	If covered pain medication requires PA, PA can't be denied if patient has terminal illness. Plan may not impose any PA for any service included in value-based payment arrangement. Gold carding in 2024. A provider w/ 90% approval rate for a service b/w 1/1/22 - 6/30/22 is exempt until 9/30/24. If utilization increase of 25% or more during exemption period, plan can rescind. By 10/1/24, plans to let providers know if exemption granted (12 months). QHPs on exchange and MCOs may develop other volume reducing plan approved by DOI to be exempt from gold card requirements.	Provider may submit a benefit inquiry to plan for service not yet provided to determine whether service meets medical necessity and requirements for payment under a health benefit plan if service were to be provided to patient. Denial must include contact info for reviewer (same specialty/ licensed in AR) whom requesting physician may have a reasonable opportunity to discuss treatment plan and the clinical basis for intervention (w/in 1 business day for urgent/2 for nonurgent). Reviewer must follow-up with decision w/in 1 business day for urgent/2 for non)

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AZ A.R.S. §20-2803		For care provided after initial screening and immediately necessary to stabilize, PA is granted unless.		Plan cannot rescind or modify PA after the provider renders care in good faith and pursuant to the authorization.		Payer cannot request info that does not apply to the medical condition at issue for the purposes of determining whether to approve or deny a PA request.					.
CA 28 CCR § 1300.67.24 HSC § 1367.01	Use and accept only the PA form (Form No. 61-211). Accept through any reasonable means- paper, electronic, phone, web portal, or another mutually agreeable method. Notices to provider delivered in same manner or another mutually agreeable method. Provider may use ePA system compliant with SCRIPT standard in place of Form 61-211.	Services: 5 business days Urgent services: 72 hours 24 hours for exigent circumstances or 72 hours for non-urgent requests of a prescription drug PA or step therapy exception request			Plan must maintain for 10 yrs. info for department upon request re: nonformulary drug requests, ST exceptions requests and PA: (1) #of requests (2) Type of specialties submitting requests, specialties reviewing initial requests & internal appeals (3) #of requests denied and reasons (4) # of requests initially approved (5) # of denials appealed internally and to external review, # upheld and reversed by internal appeal/ external review. (6) Time b/w request/approval (7) #of denials by type of provider and specialty.	Plan can request only the info reasonably necessary to make the determination. For drugs, plan that offer PA telephonically or through a web portal cannot require provider to provide more info than is required by Form 61-211 or a form or process compliant with SCRIPT standard to certain physician group processes.		Plan must provide clear explanation of specific reasons for denial of the RX PA or step therapy exception request.	No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.		A plan must cover at least at least 1 therapeutically equivalent version of a drug, device, or product for the prevention of AIDS/HIV without PA or step therapy. Rx deemed approved if plan doesn't meet response time requirements.

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CO C.R.S. 10-16-124.5 C.R.S. 10-16-113	Electronically means when the provider submits request through a secure, web-based internet portal. Does not include e-mail. Standard form	For Rx: 2 business days (ePAs); 3 business days – non-urgent (oral, fax, email); 1 business day – urgent (oral, fax, email) For medical services: 15 days non-urgent, Urgent 72 hours. For concurrent review urgent care requests involving a request by the patient to extend the course of treatment beyond the initial period of time or the number of treatments authorized: if the request is made at least 24 hours prior to the expiration of the authorized period of time or authorized number of treatments, the plan shall make a determination w/ respect to the request w/in 24 hours. 1st level review – plan has 30 days.				Must disclose list of drugs that require PA, written clinical criteria and criteria for reauth of previously approved drug after PA period expired. Require evidence-based guidelines.		Notice of right to appeal must be given to patient when PA is denied. 1st level review - reviewer must consider all comments, documents, records, and other info re: request submitted w/o regard to whether the info was submitted or considered in making the initial adverse determination.	All written adverse determinations must be signed by licensed physician familiar w/ standards of care in CO. 1st level review (appeal) must be evaluated by a physician who consults with an appropriate clinical peer unless reviewing physician is a clinical peer. The physician and clinical peer(s) cannot have been involved in initial determination but person that has involved w/denial may answer questions.		Can prospectively request peer-to-peer. Physician can request peer-to-peer re: adverse determination by reviewer making determination. Peer-to-peer must occur w/in 5 calendar days of request and be conducted b/w provider and reviewer who made determination or clinical peer if can't be available w/in 5 calendar days. Patient has right to a review meeting. Adverse determination, or w/ respect to voluntary 2nd level review of a 1st level review denial, must be reviewed by health care professional(s) w/ expertise in case.

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CT			PA lasts for 60 days unless it is reversed or rescinded	Cannot rescind a PA/refuse to pay if plan did not notify patient /provider at least 3 days prior to care.						No PA for opioid antagonists	
DE HB 381 (2016)	NCPDP standards for ePA (no standards for medical services ePA)	Drugs: 2 business days from clean PA Medical services not through ePA, 8 business days; ePA: 5 business days	Plan cannot revoke, limit, condition or restrict a PA on ground of medical necessity after date health care provider received the PA. A proper notification of policy changes validly delivered may void a PA if received after PA but before delivery of the service.		Plans must report to DHIN statistics on approvals, denials, appeals at least twice annually. Statistics to include: (1) aggregated reasons for denials; (2) For appeals: a) specialty; b) medication, diagnostic test, or diagnostic procedure; c) Indication offered; d) Reason for underlying denial; e) # of denials overturned on appeal.	Clinical criteria must be described in language easily understandable by a provider practicing in the same clinical area	60-day notice of new PA requirements.	Must make any current PA requirements readily accessible on website and in written or electronic form upon request. Requirements must be described in detail and in clear, easily understandable language.			
DC L25-0100		Urgent: 24 hours Nonurgent: 3 business days via electronic portal or 5 business days via mail, phone, fax For long-term services and supports, 30 days; provided, that enrollee has been	PA valid for at least 1 year or course of treatment regardless of changes in dosage (plan may rescind if dosage exceeds limitations set by laws or regulations)	If provider certifies in writing w/in 72 hrs that patient needed emergency care, service shall be presumed medically necessary and may only be rebutted w/ clear	Plan to make publicly available on website statistics regarding approvals, denials, and appeals, including info on the: (1) Specialties reviewing PA requests or appeals; (2) Types of medication, tests, procedures, or	Plan can only require PA for a covered service based on determination of medical necessity for different care or that proposed care is experimental or investigational.	Any changes to the requirements are not effective until the plan's website has been updated to reflect the new requirements. If plan changes cover of, or criteria for, service for	Plan must post current PA requirements including formulary, on website to be accessed by general public. Hard copy and over phone must be available on request to enrollee or provider. Requirements to	Adverse determination must be made by physician licensed to practice in DC, MD, VA in same or similar specialty (pediatric decisions must have reviewer in pediatric specialty). Reviewing physician must be under clinical direction of a medical	Plan cannot require PA based solely on the cost of service. No PA for MAT, emergency services including to screen and stabilize, pre-hospital transportation.	Prior to issuing adverse determination, plan must notify care provider that medical necessity is being questioned and give physician an opportunity to provide

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DC cont'd		determined to be otherwise eligible for such benefits under Medicaid	Chronic conditions: as long as medically reasonable and necessary to avoid disruptions in care. Plan may not revoke, limit, condition, or restrict PA if care provided w/in 45 business days from the date of notice; except in cases of fraud New plan to honor PA for 60 days. PA to be honored if new plan under same insurer.	and convincing evidence.	treatment in which approval was being sought; (3) Medical indication offered in each request; (4) Reasons for denial; (5) # of appeals taken; (6) # of appeals approved or denied; (7) Time b/w submission of request and determination; and (8) Time b/w submission of appeal and decision.		which enrollee previously received approval, change does not apply for the duration of the approval.	include written clinical criteria, list of drugs requiring PA, include process for submitting, and standards for considering, including evidence-based guidelines for PA, reauthorization, and appeals. Notice of PA decision must include the state reviewer is licensed, status of license, specialty. If denied, must include reason based on PA requirements, enrollee's right to appeal, appeal process, and info needed to support successful appeal. Plan to make enrollee's PA info from at least proceeding 5 yrs available to them.	directory licensed n DC responsible for providing health care services to enrollees in DC, not receiving financial incentives to deny care. Appeals to be reviewed by physician licensed in DC, MD, VA, practiced in same or similar specialty for at least 5 yrs, is knowledgeable of and has experience with providing care; not receiving financial incentives to deny, not directly involved in initial decision, not subordinate of physician who made initial decision.		additional info or clarification. 15 calendar days to appeal. Actions by plan that establishes a pattern or practice of repeated violations of this title, determined by Commissioner will constitute a violation of the Insurance Trade and Economic Development Amendment Act.
FL Ch. 2016-224 (627.42392) and Ch. 16 – 222	A plan that does not use ePA must use the standard PA form approved by the FSC										

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GA GA Code Ann. 33-64-8 SB 80 (2021) GA SB 341	NCPDP standard	1/1/22 – 12/31/22: response required w/in 15 calendar days of obtaining all necessary info. Beginning 1/1/23: Response requires w/in 7 calendar days of obtaining all necessary info. For urgent services no later than 72 hours after receiving all needed info.	If initial services performed w/in 45 business days of PA, may not revoke, limit, condition, or restrict except for a Schedule II controlled substance. If receive PA for drugs for patient w/ chronic condition who requires ongoing medication therapy, PA must: (1) Be valid for the lesser of: (A) 1 year from the date of PA or (B) until last day of coverage; and (2) cover changes in dosage during the period of authorization. New plan must honor old plan's PA for 30 days.		Insurers must make aggregate statistics available per insurer and per its plans regarding approvals and denials on its website in a readily accessible format. The Commissioner to determine the statistics required but must include, (1) Approved or denied on initial request; (2) Reason for denial; (3) Whether appealed; (4) Whether approved or denied on appeal; and (5) Time between submission and response.	Clinical criteria on which decision are made must be provided to provider at time of response. Change in coverage or approval criteria does not impact patient approval for remainder of plan year. Definition of medical necessity: services that prudent provider would provide for purpose of preventing, diagnosing, or treating illness, injury, or disease or its symptoms in manner that is: (a) In accordance w/ generally accepted standards of medical or other healthcare practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; (c) Not primarily for economic benefit of insurer or convenience of patient, treating physician, or other provider; and (d) Not primarily custodial care, unless custodial care is covered service.			Appeals must be review by provider who (1) Possesses a current and valid nonrestricted license or maintain other appropriate legal authorization; (2) Be currently in active practice in the same or similar specialty and who typically manages condition or disease; (3) Be knowledgeable of, and have experience providing, service under appeal; (4) Not have been directly involved in adverse determination; and (5) Consider all known clinical aspects of service under review, including, but not limited to, all pertinent medical or other records provided provider, relevant records, and medical or other literature from provider	PA cannot be required of unanticipated emergency services, urgent services, or covered services which are incidental to the primary covered service and determined by physician to be medically necessary	.

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HI	General form used by some insurers										
ID Title 41, Ch. 39 (41-3930)		2 business days after complete member medical information is provided to plan, unless exceptional circumstances warrant a longer period.		Cannot rescind approval of provided service except for fraud/ misrep/non-payment of premium, benefit exhaustion, or eligibility.							
IL Public Act 102-0409		Nonurgent request in 5 calendar days and 48 hours for urgent care 15 days for appeal decisions.	90-day period of authorization when a patients change plans Requires approvals remain valid for six months, and 12 months for chronic conditions and long-term diseases, regardless of changes in dosage Continued approval when plan's requirements change	Plans cannot deem as incidental or deny supplies or services that are routinely used as part of a health care service when: (1) an associated health care service has received PA; or (2) PA for the health care service is not required Payment (generally) if service or drug is authorized	Statistical reporting requirements include list of services/drugs subject to PA, total # of PA requests received, total # of denials and the top five reasons for denials, the # of denials appeals and whether they were upheld, and the average time between submission and response.	Clinical review criteria must be (1) based on nationally recognized, generally accepted standards except where IL law provides own standard; (2) developed in accordance w/ current standards of a national medical accreditation entity; (3) ensure quality of care and access to needed health care services; (4) evidence-based; (5) sufficiently flexible to allow deviations from norms on a case-by-case basis; (6) updated, if necessary, at least annually. "Medically necessary:" professional exercising prudent clinical judgment would provide care to a	Notice of new requirements or changes 60 days in advance	Plan to make any PA requirements including the written clinical review criteria, readily accessible and conspicuously posted on website.	Physician reviewing appeal must: (1) possess a current and valid nonrestricted license to practice medicine; (2) be in the same or similar specialty as one who typically manages condition; (3) be knowledgeable of, and have experience providing, services; (4) not have been directly involved in making adverse determination; (5) consider all known clinical aspects of service under review, including a review of all pertinent medical records and medical literature provided to plan.	An issuer must periodically review requirements and consider removal (1) where a drug/ procedure is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or (2) for patients currently managed w/ established treatment regimen.	Denials can be appealed/ reviewed by external independent review.

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IL cont'd						patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance w/ generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for convenience of patient, treating physician/ professional, caregiver, family member, or other interested party, but focused on what is best for patient's health outcome.					
IN SB 400 (2023) HR 1143 (2018) SB 73 (2017)	NCPDP standard. Required of plan and physicians. Exemptions under certain circumstances & provider to use standard form	Urgent – 48 hours Nonurgent – 5 business days. If incomplete request, must respond w/in time period. (For ePA immediate electronic receipt required.)		No retroactive denial, except if false/incorrect info provided or noncoverage on day of service. Cannot deny claims based on lack of PA for unanticipated medical service provided during authorized service.	By 2/1 every year, plan must post on its website the 30 most common CPT codes requiring PA and percentage of those codes approved.		Plans must disclose any new PA requirements 45 days before implemented (can be posted conspicuously on plan's website).	List of PA requirements by CPT code on website or portal, including specific info that must be submitted.		Prohibits prior authorization on list of CPT codes for state employee health plans. Study on impact by Nov 2025. Expires June 2026.	Peer to peer with clinical peer must be available after adverse determination w/in 7 days (if feasible).

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IA 191 IAC 79 IA HF2399 (2022)	Commissioner can consider NCPDP standards.	72 hours for urgent claims; 5 calendar days for non-urgent claims; 24 hours expedited If a request for a PA is incomplete or additional info is required, plan may request info w/in the applicable time periods. Once the info is submitted, the applicable time-period begins again. Payer must assign PA request a unique electronic ID number to track request.		Plan to pay at contracted rate per PA unless: 1. Waste, fraud, abuse 2. Inaccurate info was relied on in PA 3. Service no longer a benefit on day provided 4. provider was no longer contracted w/ plan on date care provided 5. Provider did not meet plan's timely filing requirements. 6. Plan does not have liability for a claim 7.Patient was no longer eligible				Plan must make available/ accessible on websites: a.) PA requirements, including list of drugs that require PA. b.) Clinical criteria that are easily understandable to providers, including clinical criteria for reauthorization of a previously approved drug after PA period has expired. c.) standards for submitting requests, including evidence-based guidelines.			
KS		For post evaluation or post stabilization services immediately following treatment of emergency medical condition, plan to provide access to an authorized representative 24/7.									Plan to provide patient w/ denial and description of internal appeal or review procedure, including the right to external review. Must notify patient of right to waive 2nd appeal or internal review and proceed directly to external review.

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KY KY Rev Stat § 217.211 SB 54 2019	ePA for drugs that meets the most recent NCPDP SCRIPT standard for ePA adopted by HHS. (Not fax, payer portals, electronic forms.)	Urgent: 24 hours. Nonurgent: 5 days Plans must be available to conduct review during normal business hours and extended hours on Monday and Friday through 6:00 p.m., including federal holidays. Failure to make determination and provide written notice w/in time frames will be deemed to be a PA for the services or benefits.	Valid for lesser of 1 yr or end of coverage for patient w/ a condition requiring ongoing medication therapy, and provider continues to prescribe drug. Changes in dosage don't require new PA. Does not include drugs for a non-maintenance condition; that have a typical treatment period <12 months; where evidence that does not support 12-month approval; or opioid analgesics/ben-zodiazepines	Unless otherwise specified by the provider's contract, an insurer cannot deem as incidental or deny supplies that are routinely used as part of a procedure when: (a) associated procedure has been preauthorized; or (b) PA for the procedure is not required. Plan cannot deny claim if PA not in effect on data of services on claim		"Medically necessary health care services:" Health care services that a provider would render to patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) In accordance w/ generally accepted standards of medical practice; and (b) Clinically appropriate in terms of type, frequency, extent, and duration.	Plan/UR entity must submit a copy of any changes to its utilization review policies or procedures to the DOI. No change to policies can take effect until after it has been filed with and approved by the commissioner.	Plans must make written procedures for determining whether requested care is covered, making utilization review determinations, and notifying patients and providers of determinations available on website to patients and providers. Plans must maintain info on publicly accessible website re: list of services/ codes for which PA is required including effective dates; date requirements listed; and date PA is removed if appliable. Also, must include services where PA is performed by contracted entity.	Only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, can make a utilization review decision to deny, reduce, limit, or terminate a benefit or to deny, or reduce payment for a service because that service is not medically necessary, experimental, or investigational.	Cannot require PA for births or inception of neonatal intensive care services and notification cannot be required as a condition of payment.	

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LA HB 468 (2023) SB 188 (2023) LSA-RS 22:1006.1 LSA-RS 46:460.33 ASB 348 (2022) LSA-R.S. 22:1139 SB 112 (2022)	Standard form must be accessible through multiple computer operating systems.	Plan must make a determination as expeditiously as patient's health condition requires, but not later than: -Electronic urgent – 2 business days. -Nonurgent – 5 business days. Concurrent review – 24 hours. Retrospective reviews, plan must make the determination w/in 30 business days of receiving all necessary info. Plan must provide notice of the determination in writing w/in 3 business days of determination. Plan has 1 day to inform provider of additional info necessary to make determination, and must allow provider at least 2 business days to provide the necessary info. If plan doesn't meet deadlines, cannot deny claim based on lack of PA.	Certification of PA is valid for a minimum of 3 months.	Plan cannot deny claim that received PA unless:(a)benefit limitations have been reached (b) documentation for claim fails to support claims as originally certified (c) subsequent to authorization, new services are provided or change in condition occurs and, as a result, the authorized service would no longer be medically necessary or approved under the terms and conditions for coverage (d) another payer is responsible (e)provider already been paid (f) submitted fraudulently or based on bad info or (g) patient is ineligible.	Plans to submit annual report to Commissioner containing quarterly breakdowns: (a) all items/services requiring PA (b) % of following aggregated for all items/services: (1) standard PA requests approved, (2) standard PA requests denied (3) standard PA requests approved after appeal (4) PA request when the timeframe for review was extended and approved (5) expedited PA requests approved (6) expedited PA requests denied. (c) average/median time for decision for standard and expedited PA, aggregated for all items/services. Commissioner to submit annual report to Senate/House Committees on Insurance w/ above info.	Plans, if using UR, must maintain a documented PA program that utilizes evidenced-based clinical review criteria. W/in 72 hours of receiving an oral or written request of provider, plan must provide the specific clinical review criteria used to make determination. Plan must accept any evidence-based info to assist in the determination and may only collect info need to authorize the service Plan can only require portion of medical record needed to determine medical necessity or appropriateness of service. Plan can only base determinations on medical info in patient's records obtained by plan up to the time of the review determination.	Plan must update website in timely manner to reflect changes in list of PA requirements.	Plan must maintain a system of documenting info and supporting clinical documentation submitted by providers and maintain until claim has been paid or appeal process exhausted. Plan to provide unique confirmation # to provider upon receipt of request through same medium as request was made. Upon denial, plan to provide written notification of denial and info on applicable law, reg, policy, procedure, or guideline. Prior to open enrollment, insurers must annually publish on publicly available website all items/services subject to PA according to each health coverage plan.	Upon denial, plan must include the department and credentials of person authorized to approve or deny the request, a number to contact the authorizing authority, and a notice of patient's right to appeal. If upon denial, provider requests a peer review, plan must appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct it. (Same or similar specialty mean training and experience in treating condition and treating complications that may result from service/procedure.) When peer review is requested by a physician, plan must appoint a physician to conduct the review	Plans must maintain program that allows for selective application of PA requirements based on stratification of providers' performance and adherence to plans' PA criteria. Criteria for participation and the services included to be at the sole discretion of the plan. (Cannot include Rx) Plans can't impose any additional PA requirement w/ respect to surgery/ invasive procedures that has received PA during perioperative period.	Plan must notify physician of its peer review determination within 2 business days of the date of the peer review.

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ME Chapter 273 PL S.P. 218- L.D. 705 2019	Must accept/ respond through secure electronic transmission using NCPDP standards for eRx - fax, payer portal, or via electronic form is not electronic transmission	Nonemergency: Lesser of 72 hours or 2 business days (notify provider and patient). If additional information needed, lesser of 72 hours or 2 business days from receiving info. If outside consultation needed, 72 hours or 2 business days from plan's initial response.		When PA for service/covered item is granted, plan can't retrospectively deny coverage/ payment for approved service unless fraudulent or materially incorrect info was provided.		Plan must use documented clinical review criteria based on published sound clinical evidence and which are evaluated periodically to assure ongoing efficacy. (May develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.) Must make available upon to Superintendent and Commissioner of Human Services.				Plan can't require PA for MAT for the prescription of at least one drug for each therapeutic class of medication used in MAT, except that plan may not impose any PA on a pregnant woman for MAT.	
MD MD Code Ann. 19-108.2 MD Ins Code § 15-851 (2019)	Online process for accepting PA electronically. Plans must establish an online PA system for drugs & for step-therapy	Real time for ePA (drugs) that meets criteria, and no additional info is needed. 1 business day for non-urgent drug; 2 business days non-urgent services (electronically)						Online access for providers to health care services requiring PA and key criteria for making a determination. Unique electronic identifier that provider can use to track PA.			
MA MGL C. 1760, 25	Must be available electronically Standard form	2 business days after receiving completed PA request.				Plans can develop clinical criteria to determine medical necessity but must be, at a minimum: (a) developed w/ input from practicing physicians and participating providers in service area; (b) in accordance w/ national accreditation orgs;		Clinical criteria to be provided w/ adverse determination, upon request to Office of Patient protection, upon request to public, upon request to enrollees and prospective enrollees, and providers. Must be			

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MA cont'd						(c)updated at least biennially; (d) evidence based, if practicable; (e) applied so as to consider patient's individual needs and (f), assessed by plan to show compliance w/ parity requirements.		public on website (if not proprietary).			
MI Section 500.2212c SB 247 (2022)	ePA requirements on plans and providers	9 days for nonurgent until May 31, 2024, and then drops to 7 days. 72 hours for urgent	PA is valid for not less than 60 calendar days or for clinically appropriate duration, whichever is later.		Every year, plan must report to department on department, aggregated trend data related to their PA practices and experience for the prior year: (a) # of PA requests. (b) # of PAs denied. (c) # of appeals received. (d) # of adverse determinations reversed on appeal. (e) Total # PA requests, the # of requests that were not submitted electronically. (f) Top 10 services denied. (g) Top 10 reasons PA requests denied. On 10/1 every year, dept. aggregates data into report.	PA requirements to be based on peer-reviewed clinical review criteria developed by (1) entity working directly w/ clinicians to develop clinical review criteria, and does not receive direct payments based on outcome of clinical care decision; or (2) Medical specialty organization. Clinical review criteria must: - Consider needs of atypical populations/ diagnoses -Ensure quality of care & access -Be evidence-based -Sufficiently flexible for all deviations from norms (on case-by-case basis) -Be reevaluated & updated when needed/ at least annually.	For drugs, plan must notify providers via plan's provider portal of new or amended PA requirements at least 45 days before implemented. For services, must notify at least 60 days before implemented.	Plan to make PA requirements, including written clinical review criteria, readily accessible and conspicuously posted on website.	Denial upon appeal must be reviewed by licensed physician, board certified or eligible in same specialty as a provider who typically manages the medical condition or provides the service. If plan can't ID a licensed physician who meets requirements w/o exceeding time limits, plan may use licensed physician in similar specialty as considered appropriate, determined by plan.	Plans must adopt a program that promotes the modification of PA requirements of certain prescription drugs, medical care, or related benefits, based on the performance of the providers w/ respect to adherence to nationally recognized evidence-based medical guidelines and other quality criteria.	

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MN M.S.A. § 62M.05; M.S.A. § 62M.06 M.S.A. § 62M.07 SF 3204 2019	NCPDP standard mandated for prescribers and plans. If PA requirements for health care service, must allow providers to submit requests by telephone, fax, or voice mail or through an electronic mechanism 24 hours/day, 7 days/week Standard form: Sec. 4. MN Statutes 2018, section 62M.04, subdivision 3 limited	Nonurgent: 5 business days (must provide "audit trail" of notification.) Expedited determination required if provider says warranted. No later than 48 hrs and must include at least 1 business day after the initial request. When expedited denial made, must also notify patient and provider of right to submit expedited appeal. Plan must notify in writing patient, provider, claims administrator of determination on the appeal w/in 15 days after receipt of the notice of appeal. If plan entity can't make determination w/in 15 days due to circumstances out of its control, may take up to 4 additional days. Any more and must inform parties of reason. Reviewer cannot be physician who made adverse determination.	When patient changes plans, PA good for 60 days - provider/ patient must submit documentation of previous PA to new plan.	May not revoke, limit, condition, or restrict a PA unless there is evidence that the PA was authorized based on fraud or misinformation or a previously approved PA conflicts w/ state or federal law.	Every April, plans must post: (1) # of PA requests for which an authorization was issued; (2) # of PA requests that adverse determination was issued and sorted by: (i) service; (ii) whether appealed; and (iii) whether upheld or reversed on appeal; (3) # of PA requests submitted electronically (4) reasons for denials including but not limited to: (i) patient did not meet PA criteria; (ii) incomplete info submitted; (iii) change in treatment program; (iv) patient no longer covered.		Electronic notice of new/amended requirement must be sent 45 days in advance to all MN-based, in-network providers subject to requirements. If, during plan year, coverage or clinical criteria change, does not apply until the next plan year for patients who already received PA. Does not apply if deemed unsafe, if research/ clinical guidelines or evidenced-based standards changes for patient harm reasons; or if replaced w/ generic rated as equivalent or biologic rated as interchangeable and 60-day notice given.	Upon request, plans must provide criteria used to determine necessity, appropriateness, and efficacy of service and identify database, professional treatment parameter or other basis for the criteria. Plan must post on its public website PA requirements of organization that performs their PA. Plan must have written standards: (1) procedures and criteria used to determine if care is appropriate, reasonable, or medically necessary; (2) system for providing prompt notification of determinations and appeal procedures; (3) compliance w/ time frames; (4) procedures to appeal denial; (5) procedures to ensure confidentiality of patient info.	In appeals to reverse an adverse determination for clinical reasons, the plan must ensure that a physician of plan's choice the same or a similar specialty as typically manages the medical condition, procedure, or treatment is reasonably available to review the case. No individual who is performing utilization review may receive any financial incentive based on the number of adverse determinations made provided that utilization review organizations may establish medically appropriate performance standards.		

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MS MS Code 2015 83-9-63	Standard form – cannot exceed 2 pages and must be available electronically.	2 business days of receiving completed request on standard form.									
MO Mo stat. 376.1350 -376.1389 SB 982 (2018)		2 business days after obtaining all necessary info. For concurrent review: w/in 1 working day of obtaining all necessary info		If plan authorizes services, cannot retract authorization after care provided or reduce payment for service unless (1) based on a material misrepresenta-tion or omission re: patient's health condition or cause of condition; or (2) plan terminates before the health care services are provided; or (3) coverage under the health benefit plan terminates before services are provide		Plans to use clinical review criteria based on sound clinical evidence. Plan may develop own clinical review criteria, or purchase or license clinical review criteria from qualified vendors. Plan to make available clinical review criteria upon regulator request. Can collect only info necessary to certify admission, procedure/ treatment, length of stay, frequency and duration of services. If plan provides drug coverage, it must provide coverage for any drug prescribed to treat an indication so long as drug is FDA-approved for at least 1 indication, if drug recognized for treatment of covered indication in 1 of the standard reference compendia or in accepted medical literature and deemed medically appropriate.		Plan must implement a written utilization review program that describes all review activities and must file an annual report of its utilization review program activities w/ the DOI.	Any medical director who administers the UR program or oversees review decisions must be a qualified health care professional licensed in MO. A licensed clinical peer shall evaluate the clinical appropriateness of denials. Compensation to reviewers cannot incent denials.		Appeals: - 1st level: insurer conducts investigation; -- 2nd level: submitted to an insurer-specific panel for review; -3rd level: insurance director hires appeals review org. Plan to provide enrollees and providers w/ timely access to review staff by a toll-free number.

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MT SB 0380 (2023) § 33-32-101-107		Care for post-evaluation/ post-stabilization services required immediately after emergency services, plan must provide access to an authorized representative 24/7 to facilitate review.	PA is valid for at least 3 months from date the provider receives certification unless the covered person loses coverage under the applicable health plan or health insurance coverage.			Medical necessity: health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are: (a)in accordance with generally accepted standards of practice; (b)clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (c)not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.	Drug benefit: if plan implements new or amended plan, including new or amended clinical criteria, standards, procedures, requirements, or restrictions, may not implement change until: a) notified providers in writing of new/ amended plan restrictions, at least 60 days before; and (b) updated website, to make info accessible to covered persons, prospective covered persons, and health care providers. Plan or UR entity must display on public website current Rx benefit info, including formulary lists.	Plan to maintain and provide at com-missioner's request a UR plan that includes: (1) description of criteria, standards, and procedures used in evaluating services that, to the extent possible, must: (a) be based on nationally recognized criteria, standards; (b) reflect community standards of care, (c) ensure quality of care; and (d) ensure access to needed services; (2) policies/ procedures to ensure entity conducting review is reasonably accessible to patients/providers at all times; (3) policies/ procedures to ensure compliance w/ all laws to protect medical record confidentiality; (4) copy of materials designed to inform patients/ providers of requirements of plan.	Any adverse determination for a drug must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the drug was prescribed to treat.	No PA permitted for: -generics after person prescribed them for 6 months at same quantity - any drug solely because the dosage has been adjusted if w/in FDA guidelines or consistent with clinical dosing -any long-acting injectable antipsychotic.	

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NE § 44-5426						Plans must use documented clinical criteria based on sound clinical evidence and evaluate periodically. Plan may develop its own clinical criteria or purchase/license criteria from qualified vendors. Must be available to authorized government agencies.			A plan must ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise		A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.
NH NHRSA 420-J; 5, 7-b 415-A:4-b 417-F:3 Section 420-J:18	ePA w/ NCDPD standard permitted. Plan cannot use ePA when: pharmacist/ prescriber: (1) lacks internet access; (2) has low patient volume; (3) opted-out for certain medical condition or patient requests; (4) lacks EMR or when (5) ePA interface does not allow pre-population of prescriber & patient info; (6) ePA interface creates prescriber costs.	48 hours for medically necessary non formulary Rx drug Urgent care: 72 hours Urgent and relating to the extension of an ongoing course of treatment and involving a question of medical necessity: 24 hours 15 days for non-urgent			Annual reports must be made to the insurance commissioner regarding plan complaints, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.	Clinical review criteria considered or utilized in making claim benefit determinations shall be: (a) Developed with input from appropriate actively practicing practitioners in the carrier or other licensed entity's service area; (b) Updated at least biennially and as new treatments, applications, and technologies emerge; (c) Developed in accordance with the standards of national accreditation entities: (d) Based on current, nationally accepted standards of medical practice; and (e) If practicable, evidence-based.				Can't require PA for medically necessary interfacility transports for services related to the treatment and diagnosis of certain biologically-based mental illnesses. Whenever SUD services are covered benefit, plan must offer at least one MAT therapy option approved by the FDA w/o PA and cannot require a renewal of a PA for MAT for SUDs more frequently than once every 12 months.	Expedited appeal related to an urgent care claim, must make decision as expeditiously as the medical condition requires, but in no event more than 72 hours after the appeal is filed. If involves ongoing urgent care services, service can be continued without liability to patient until notified of determination. Denial on appeal to include notice of right to external review/ specific requirements for filing.

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NM NM Stat § 59A-22-52 (2013) SB 188 (2019)	Standard form-drugs and services Plans must establish electronic portal system for secure electronic transmission of PA requests 24/7	7 days Expedited: 24 hours			Each Sept. OSI report to Gov/ legislature:(1) data for each plan individually and collectively; (2) the # and nature of complaints against plan for failure to follow Act; and (3) OSI actions taken including fines.						
NJ P.L. 2023, c. 296 (2023) P.L. 2005, C. 352	For drug benefit: NCPDP SCRIPT Standard for ePA. Mandated on plans and providers by 2027.	Drugs using ePA within 24 hours for urgent requests and 72 hours for nonurgent requests after obtaining all necessary info. Inpatient hospital services and outpatient setting:12 days or 9 days if submitted through electronic payer portal. Requested inpatient services when patient is already inpatient at hospital or ED: 24 hrs. Urgent care: 72 hours. For immediate post-evaluation or post-stabilization	PA for chronic or long-term care condition valid for 180 days except where shorter time needed to monitor safety or treatment effectiveness. PA for service which includes defined # of discrete services w/in a timeframe are valid for 180 days. Plan cannot revoke, limit, condition or restrict, if patient is still eligible, no misrepresent-ation and no material	If patient no longer eligible under plan after PA provided, but has coverage under another plan, new plan must accept PA and pay provider. Plan must pay provider according to contract for all covered medically necessary emergency and urgent services including all tests needed to determine the nature illness or injury; pre-hospital transportation;	Plans much make statistic available on website and include categories for: a. provider specialty; b. medication or diagnostic tests and procedures; c. indication offered; d. reason for denial; e. whether PA determinations were:(1) appealed; or (2) approved or denied on appeal; f. time b/w PA submission and determination; g. average median time elapsed b/w a request for clinical records from requesting provider and receipt of clinical records; and	Medically necessary: service a provider, exercising prudent clinical judgement, would provide for evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance w/ generally accepted standards of medical practice; clinically appropriate, in type, frequency, extent site and duration, & considered effective for patient's illness, injury or disease; not primarily for convenience of patient or provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent	For services (not drugs), plans must provide contracted providers written notice of new or materially adverse changes 90 days in advance and update website. If change in coverage or criteria and service has been previously authorized, change cannot impact patient for reminder of plan year.	Plan must post on website w/in 30 days of taking effect: (1) source of all commercially produced clinical guidelines (2) list of info required to be submitted w/ claim for payment (3) description of type of claims for which submission of additional info is required (4) payer's policy for reducing payment for reducing payment for a duplicate/ subsequent service provided on same data of service (5) drug formularies. (6) info commissioner deems necessary.	Denial to be made by physician under clinical direction of medical director licensed in NJ, not compensated based on approval/ denial rates, and not provided preferential treatment by plan in request for PA of reviewing physician if physician is also in plan's network. On appeal, must be reviewed by board certified physician in same or similar specialty w/ experience treating condition/service or has treated condition in last 5 yers; not paid by plan based on reviewing physician's denial/approval rate;		Provider does not have independent right to appeal an adverse determination but patient may permit. Plan violation of certain provisions: $10,000 for each day. At discretion of commissioner, plan has 30 days, or such additional time as the commissioner determines.

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NJ cont'd		services following emergency care, 150 minutes. Plan can't deny based on lack of PA when provider requests PA but plans fail to respond w/in time frames.	change in clinical condition. 60-day grace period when switching plans. When switching products under same payer, payer must honor PA if covered benefit.	or the provision of emergency services.	h. number of appeals generated for cases denied in which there was inadequate or no prior clinical information.	therapeutic or diagnostic results.		Payer cannot amend a claim by changing diagnostic code assigned to services rendered w/out providing written justification.	not directly involved in initial decision; consider all known aspect of service including review of provided medical records, and medical literature provided by provider; not be provided preferential treatment; and engage in phone conversation with treating provider is requested.		
NY NY Ins L § 3238 (2012) §3217-A SB 4721A (2016) §4902, 4903 and 4904 https://www.nysenate.gov/legislation/laws/ISC/3238 (2020)	Standard form Take into account NCPDP standards	If request is complete, w/in 3 business days of receipt. If incomplete, w/in the earlier of 3 business days of receipt of necessary info, 15 days of partial, or 15 days of end of 45-day period if no additional info received. For urgent/ expedited: If request complete – w/in 72 hrs. If incomplete w/in 48 hrs. of earlier of receipt of necessary info or end of 48 period.		Plan to pay claims when PA was received prior to care, unless patient ineligible at time of care, claim was not timely, inaccurate info submitted, or fraud. When providing service, if provider determines related service is immediately necessary, and in clinical judgment is medically timely and would not be advisable to interrupt provision of care		For SUD treatment, a plan must use evidence-based and peer reviewed clinical review tool appropriate to patient's age. When conducting UR for treatment provided in state, must use evidence-based peer reviewed clinical tool designated by office of alcoholism and substance abuse services. For mental health care, Plans must use evidence-based peer reviewed clinical review criteria appropriate to patient's age and deemed appropriate for such use by commissioner of the office of mental health,		Plans to disclose to prospective enrollees description of all PA requirements for treatments/services; circumstances when used, response times, notice that denials will be made by qualified clinical personnel and denials notices will include info re: basis of decision; notice of right to external appeal w/ a description of process. Notice of denial to include reasons for determination including clinical rationale and what	For adverse determinations – a clinical peer. Appeals: Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination)	No PA for services provided in a neonatal intensive care unit of a general hospital.	Expedited appeal decision 2 business days, for expediated SUD treatment appeals—24 hours. Notice of appeal decision to include clinical rationale for determination; and notice of right to an external appeal If denial w/o attempting to discuss w/ provider, must provide opportunity to request a reconsideration.

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NY cont'd		Court ordered treatment – 72 hrs. Preferred drug program must make available a 24 hr per day, seven days per week telephone call center that includes a toll-free phone line and dedicated facsimile line to respond to PA requests		for a PA, plan cannot deny payment unless service was (1) not covered benefit (2) not medically necessary; (3) investigational/ experimental.		in consultation with the commissioner of health and the superintendent.		info needed to render decision on appeal, how to initial appeals			Must occur w/in 1 business day of receipt of request and conducted by provider and clinical peer reviewer making initial denial or designated clinical peer reviewer if original reviewer unavailable.
NC N.C. Gen. Stat. 58-50-61 N.C. Gen. Stat. 58-3-200(c).		3 business days after receipt of all necessary information.		Plan may not retract determination after services provided, or reduce payments, unless based on material mis-representation re: patient's condition that knowingly made by patient/ provider.				Written notice of a non-certification must be submitted to provider and patient - include all reasons for denial. Notice must include instructions to pursue informal reconsideration, or appeal (either on expedited or non-expedited basis).	Qualified health care professional must administer UR program and oversee review decisions under direction of a physician. A physician licensed in NC must evaluate clinical appropriateness of all non-certifications.		Violations may subject plan to enforcement action by DOI which may include civil penalties, restitution, or licensure action.
ND SB 2389 (2023) ND Cent Code 23-01-38	Rx PA to be accessible electronically. Fax is not electronic.										2023-2024 PA interim study on impact on patients, providers, insurers including burden, time, costs, utilization.

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OH SB 129 (2016)	NCPDP standard for Rx and CAQH operating rules for info exchange in medical benefit. Electronic submission does not include fax or payer portal not using NCPDP standard.	48 hours for urgent 10 calendar days for non-urgent after receipt of all necessary info. Appeals: For urgent services – 48 hours. For other services – 10 calendar days.	For PAs related to drugs for chronic conditions, plan must honor PA for the lesser of 12 months from approval or the last day of eligibility. Plan may require a provider to submit info indicating that the patient's chronic condition has not changed not more than quarterly. (Provider must respond w/in 5 days.)	No retroactive denials if medical necessity/ eligibility requirement met. Upon written request, plan must permit retrospective review if PA not obtained if service was (i) directly related to another service for which PA obtained and performed; (ii) service was not known to be needed when original service performed and (iii) need for service revealed when original service was performed. Plan can't deny claim for such service solely for lack of PA.			Disclose new requirements 30 days in advance via email or standard mail and must be entitled "Notice of Changes to Prior Authorization Requirements.	Plan must make available to all participating providers on its website or provider portal a listing of PA requirements, including info or documentation that a practitioner must submit in order for PA request to be considered complete. Plan must make available on website info about policies, contracts, or agreements offered by plan that clearly identifies specific services, drugs, or devices to which a PA requirement exists.	Appeals must be between the provider and a clinical peer.		Enforcement: committing a series of violations that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice. After appeal process, can go to external review. If unintentional error on claims results in a claim that does not match the info originally submitted in the approved PA, upon receiving a denial, physician may resubmit the claim.
OK §6907 63 OK Stat 63-313B	Plans to use a 3-page form for Rx (not standard)					HMO must establish procedures that ensures services provided to patients are rendered under reasonable standards of quality of					

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OK cont'd						care consistent with prevailing professionally recognized standards of medical practice. Procedures to include mechanisms to assure availability, accessibility and continuity of care.					
OR HB 2517 (2021)	Standard form for Rx. Must be electronically available Provider can make a secure electronic submission, meeting industry standards for privacy, along with needed documents, and receive an electronic acknowledge-ment of receipt of request.	Nonemergency service: 2 business days. If additional information is request, decision must be made 2 business day after receipt of info, or 15 days after date of request.	PA (not Rx), binding for later of: reasonable duration of treatment based on clinical standards; or 60 days after date treatment begins after approval For Rx: 1 yr from date treatment begins after approval if drug is prescribed as maintenance therapy (last at least 12 mos based on medical or scientific evidence) and prescribed throughout 12-mon period.	Except in the case of misrepresentatio n relevant to a request for PA, a PA determination is binding on the insurer of length of PA (see previous column)	Plans much provide to Department an annual summary of PA requests: (A) # of requests received; (B) # of requests denied and reasons including, lack of medical necessity or failure to provide additional clinical info requested by plans; (C) # of requests that were initially approved; and (D) # of denials that were reversed by internal appeals or external reviews.	May only require the minimum amount of material info necessary to approve/disapprove the Rx. Plan must use evidence-based clinical review criteria, continuously updated based on new evidence and research, and take into account new developments in treatment.	60-day notice of new requirements If change in formulary or coverage impacts coverage of treatment plan and patient has been stabilized for at least 90 days, plan must continue to provide coverage of the treatment until utilization review, internal and external reviews are completed.	Plan to post on website requirements for requesting coverage of treatment subject to utilization review, including specific documentation required, and list of treatments, subject to utilization review. Notice of denial must be written in plain language, understandable to providers and patients, and include the specific reason for the denial based on evidence-based, peer reviewed literature. If based on terms in a policy or certificate of insurance, denial must cite the specific language.	Plans must use OR-licensed physician to make all final recommendations regarding coverage for care subject to utilization review and to consult as needed. For IRO, at least one reviewer must be a clinician in same or a similar specialty as the provider who prescribed the treatment.	A PA may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer	Any denial must be given timely appeal before appropriate medical consultant or peer review committee. Qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

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PA Act 146 (2022)	Plans to have portals that allows for submission of PA request, access to the medical policies, info needed to request Peer-to-Peer, and contact info for clinical/ admin staff. Plans have to offer training for providers. Providers must us portal to submit PA request (some exceptions).	For Medicaid or CHIP managed care plan: 2 business days after receipt of all info. For urgent care under commercial plans: 72 hours For nonurgent under commercial plans: 15 days		Plan cannot deny a "closely related service" based on lack of prior auth if plan is notified of closely related service w/in 3 days and prior to the submission of the claim.		Medical policies to be reviewed at least annually. Clinical criteria must be based on applicable nationally recognized medical standards; be consistent w/ applicable governmental guidelines; provide for delivery of a service in a clinically appropriate type, frequency and setting and for a clinically appropriate duration; reflect current medical and scientific evidence on emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature.	Notice to be provided 30 days in advance of new policy	Medical policies must be made available on website and through portal and include the clinical review criteria used to develop the policy. Plan must send a notice of denial to patient and must include statement specified in the law that outlines right to an appeal and external appeal.	Licensed provider w/ appropriate training, knowledge, expertise in same/similar specialty or, licensed provider in consultation w/ appropriately qualified 3rd-party health care provider, licensed in same/similar specialty or type of provider who manages condition. Internal/ external grievance process for Medicaid/CHIP/ MCOs: licensed physician in same/similar specialty that typically manages service. IRO review for commercial plans: physician or appropriate provider w/ expertise in treatment of condition and has recent or current actual clinical experience.		Peer-to-peer review: plan to make available a licensed health care professional w/ authority to overturn or modify PA decisions. P2P available b/w denial and internal grievance process or internal adverse benefit determination process. Process for requesting P2P to be on plans' website and portal. Statute established state external review process. One level of internal review and then 1 level of external review by IRO (DOI oversees).

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RI SB 290 (2023) R23-17.12-UR § 27-18.9		15 business days for non-urgent, 72 hours for urgent/emergent. Allow for direct contact with peer reviewer.		Plan cannot retrospectively deny PA for services provided unless approval was based on inaccurate info material to review, or services were not provided consistent w/ submitted plan of care and/or any restrictions included in the PA granted by review agent.				A utilization review agent cannot conduct utilization review for services delivered or proposed to be delivered in RI unless the Department has granted the review agent a certificate. No reviewer will be compensated, paid a bonus, or given an incentive, based on making an adverse determination.	All initial, prospective and concurrent adverse determinations and all first level appeal adverse determinations shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician	Commissioner to establish workgroup representing providers and insurers that will, develop/promote guidelines on selective PA programs; review of services/drugs subject to at least annually; transparency accessibility of PA criteria and requirements, timeliness of PA; and continuity of patient care.	A 1st and 2nd level appeal adverse determinations cannot be made until appropriately qualified and licensed review provider has spoken to, or otherwise provided for, an equivalent 2-way direct communication w/ patient's attending physician unless physicians choose not to or is not available.
SC											
SD								Plans to provide written info re: PA to perspective enrollees, description of easily accessible method to obtain a PA or step requirement for each specific drug on formulary			
TN Tenn. Code § 56-7-3701	Plan must accept and respond electronically to PA submitted through a secure electronic transmission as	Urgent: 72 hours plus 1 additional business day (1st weekday not designated as a state or federal holiday) if applicable.	PA valid for at least 6 months from the date approved. 90-day grace period when	Must pay at contracted rate for service if PA approved except in cases of fraud, provider is not longer	Plan to post on website deidentified. aggregate statistics available by service code on approvals and denials	Clinical review criteria to be based on nationally recognized, generally accepted standards for national, clinical criteria, except where state law	Plans must give notice of new requirements, restriction or amendment to PA 60 days before change or	With notice of denial, plan to include related evidence-based criteria, description missing/insufficient documentation or	Adverse determination (not drugs) to be made by licensed physician or healthcare professional w/ same or similar specialty.	No PA for treatment for OUD (excludes behavioral health inpatient) At least annually, plan must review its PA	Adverse determination appeals that are not submitted electronically should be processed in

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TN cont'd	determined by the carrier or organization. (b) If PA for drug is submitted electronically using the NCPDP SCRIPT Standard for ePA, then plan must accept and respond using same standard. (Doesn't require provider to submit PA electronically.)	Nonurgent: 7 calendar days. Plans has 5 days after physician submits additional info requested. Nonurgent care deemed approved w/in 7 calendar days, if plan fails to approve or deny the request; fails to request all additional info needed; or, except of PA for drug, fails to notify provider that PA is being questioned for medical necessity	switching plans. And must honor PA if switching products under same insurer.	contracted on date of service, plan has no liability. Must pay provider for performing service if PA was obtained by another healthcare provider Plan to pay for services retroactively deemed medically necessary, regardless of when PA approve for a max period of 18 months. Plan can't deny claim for closely related service to one that received PA.	including, (1)#number of initial requests approved or denied during the previous benefit plan year (2) # of PA requests appealed (3)# of appeals overturned and #granted (4) time b/w submission of initial request and response (5) top 5 reasons for denial (6) average time b/w submission and response (7) average time b/w submission and response for appeal of a prior (8) Any other info commissioner determines appropriate.	provides its own standard; not arbitrary and must be cited by the utilization review organization; developed in accordance w/current standards of a national medical accreditation entity; ensure quality of care and access to needed healthcare services; evidence-based; sufficiently flexible to allow deviations from norms when justified; and be evaluated and updated.	45 days for drugs. If plan changes coverage or approval criteria for previously authorized service, then must not affect enrollee who received PA before effective date change for remainder of the plan year.	lack of coverage for service; how to file appeal; additional documentation needed to support appeal. Health plan is responsible for monitoring utilization review org's activities Plan to make all current PA requirements readily accessible on its website to providers.	Electronic appeals: licensed physician or a healthcare professional w/ same or a similar specialty, have experience providing or be knowledgeable re: care, not directly involved in initial decision, and consider all known clinical aspect of service, including medical records and medical literature provided. For mental health and SUD care, person performing review in appeal must be both licensed at independent practice level and in appropriate mental health or chemical dependency discipline	requirements and consider removal where a prescription or service check is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications.	accordance w/ NCQA standards. Plan must notify physician PA is being questioned for medical necessity (not drugs). Plan to provide # to utilization review organization; business hours of physician w/ decision-making authority; and statement of opportunity to discuss medical necessity directly w/ person responsible for decision. Physician must submit PA w/in 5 days prior to care (not drugs) for non-urgent PA
TX TX Ins. Code 1369.304 and TX Admin Code 19.1820 SB1742 2019	Standard form for Rx, consider national standards. Must be available electronically (applies to all plans, Medicaid, CHIP)	If noncompliance w/ respect to publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any service affected.			Plan must post on website statistics on approval/denial rates for service in the preceding year, including statistics in the following categories:(i) physician or provider type and specialty;		Insurer to provide 60-day notice of new or amended PA requirements (5 days if removing PA or making a change that reduces burden)	Plan must provide to any preferred provider a list of services that require PA and info on the PA process w/in 5 business days. Plan must post PA requirements on website	Plan's review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in TX and conducted in accordance w/ standards developed	Gold carding: A physician or provider will receive an exemption from PA for a service from a plan if, in a 6-month period, receive 90% approvals for prior auth requirements for that service.	Before adverse determination based on medically necessity, appropriateness or experimental or investigational nature of service, provider to be able to discuss w/

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TX Cont'd	By the 2nd anniversary of adoption of national standards for ePA, a plan must respond via ePA when prescriber initiates a request electronically.				(ii)indication offered; (iii)reasons for denial; (iv)denials overturned on internal appeal; (v) denials overturned by an independent review org; (vi) total annual PA requests, approvals, and denials for service			(conspicuously, easily searchable, and w/o needing login) and include: the effective date of PA requirement; a list of any supporting documentation required; screening criteria, which may include CPT/ICD codes. Insurer may, instead of making info publicly available on website that may violate copyright law or licensing agreement, supply summary of w/held info sufficient to allow provider to understand basis for determinations.	w/ input from appropriate health care providers and approved by a physician licensed to practice medicine in TX. A utilization review agent must conduct review under the direction of a physician licensed to practice medicine in the state.	Plans are prohibited from requiring more than one PA annually for a drug used to treat an autoimmune disease, hemophilia, or Von Willebrand disease.	a licensed physician If w/in 10 working days after appeal is requested or denied, provider requests a particular type of specialty provider review, a provider who is of the same or a similar specialty must review denial or decision denying appeal. Specialty review to be completed w/in 15 working days. Must have expediated appeal procedures for denial of emergency care, continued hospitalization, or other service if provided written statement and supporting documentation that necessary to treat life-threatening condition or prevent serious harm.

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UT 31A-22-650				Plan cannot revoke PA if eligibility requirements met, accurate claim, and not based on fraud/materially incorrect info.	Plan must report to department, for previous calendar year, percentage of authorizations, not including a claim involving urgent care, for which the plan notified a provider of decision more than 1 week after the day on which the plan received the request.		Plan must notify on website, and if request by network provider via mail or email, 30 days before change takes effect.		Appeal of adverse determination may only be reviewed by a licensed physician. Appeal of adverse determination of a drug, may only be reviewed by individual currently licensed in US state, district, or territory as physician, surgeon; or pharmacist.		
VT 18 VSA 9418b.	PA form must include set of common data requirements for nonclinical info for PA included in the 278 standard transaction, national standards for PA, and e-prescribing. (Workgroup decided to move forward only w/ medical services.) Plan must accept the national standard transaction info, such as HIPAA 278 standards for sending or receiving PA electronically.	Respond to completed prior auth in 48 hours for urgent care and 120 hours for non-urgent. The plan must notify the provider or make available to a health care provider a receipt of the request for prior auth and any needed missing information within 24 hours of receipt.								By 1/15/22, plans w/ 1000+ enrollees must implement pilot that automatically exempts or streamlines certain PA requirements for subset of providers (some must be primary care.) Plans must make publicly available procedures that are exempt. criteria to qualify; # of eligible providers and specialty; etc. Report to leg. and Green Mountain Care board by 1/5/23.	

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VA § 38.2-3407.15:2	ePA using NCPDP standard. By 2025, plans must have online process linking directly to all e-Rx systems/EHRs using NCPDP SCRIPT standard and RTBS standard; can accept/approve ePA requests; links to real-time patient OPP costs. Plans can't charge to access process. Plans cannot access provider data via online process other than for enrollee. By 7.1.24, plans must provide contact info of any third-party vendor used to meet requirements upon provider request. Providers to ensure their e-prescribing and EHR system can access the ePA process and RTB info at point of prescribing.	Plan must notify the provider after submission of complete request w/in 24 hours (including weekend hours) for urgent, W/in 2 business days of submission of a fully completed PA request, plans must communicate to prescriber if request is approved, denied, or requires more info. Tracking system should be available.	Honor PA for at least 30 days when patient switches plans. Honor PA for drugs (not opioids) w/ dosage change. Honor PA if patient changes plans w/ same insurer. No repeat PA for approved formulary drug for treatment of mental illness if (i)covered; (ii)does not exceed FDA-labeled dosage; (iii)issued continuously for at least 3 months; (iv) prescriber performs annual review. Honor PA for drug regardless if removed from formulary once prescribed.	If during a authorized invasive/surgical procedure, provider discovers clinical evidence to perform a less or more extensive or complicated procedure, then plan must pay claim if (i) not investigative in nature/medically necessary as a covered service; (ii) appropriately coded; and (iii) compliant with post-w/ claims process.				Plan's formularies, PA requirements and request forms must be available on plan's website and updated w/in 7 days of changes.		No PA for at least 1 drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine;	Stakeholders to convene workgroup to look at common evidence-based parameters for plan approval of 10 most frequently prescribed chronic disease management drugs subject to PA, 10 most frequently prescribed mental health prescriptions subject to PA, and generics subject to PA.

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WA HB 1357 (2023) SB 5346 CR-103	For services, by 2026, plans to build/ maintain API for providers to determine whether PA is required, identify requirements, and facilitate exchange of requests/ determinations from EHR or practice management system. API must use HL7 standards in accordance w/ federal requirements; automate process to determine if PA required for DME/service; let providers query plan's PA documentation requirements; support automated approach using nonproprietary open workflows to compile and exchange necessary/ allowable data; indicate denial or authorization	If submitted through electronic processes such as web portals: 1 calendar day for expedited requests and 3 calendar days for standard requests (excluding holidays) If submitted through non-electronic processes such as faxes: 2 calendar days for expedited requests and 5 calendar days for standard requests. If insufficient info has been provided to the plan, plan must request additional info w/in 1 calendar day.	PA cannot expire sooner than 45 days from date of approval		Plans must report to commissioner deidentified, aggregated data for prior plan year for inpatient and outpatient med/surg; inpatient and outpatient mental health and SUD; diabetes supplies and equipment; DME; prescription drugs. Data to include: • 10 codes w/ highest # of PA requests and percent approved. • 10 codes w/ highest percentage of approved PA requests and total # of requests. • 10 codes w/ highest percentage of PA requests initially denied and then approved on appeal and total # of such requests. Plan to include average response time in hours for requests in each covered service for expedited decisions; standard decisions; extenuating-	PA requirements must be based on peer-reviewed clinical review criteria. Criteria to be evidence-based, accommodate new info related to appropriateness of clinical criteria w/ respect to black and indigenous people, other people of color, gender, and underserved groups. Criteria to be evaluated and updated, if necessary, annually. Plans make most current requirements, including clinical review criteria, available to providers in electronic format upon request. Plan must (a) accept any evidence-based info from provider that will assist in the process; (b) collect only info necessary to authorize service and maintain a process for provider to submit records; (c), require only the section(s) of medical record necessary to determine medical necessity or	Plans must give providers 60-days' notice before making any changes to its PA program, including addition of new PA requirements to services or changes to the clinical criteria used to consider PA requests.	Denial must include specific reason and if based on clinical review criteria, the criteria must be provided. Denial must include the department, credentials and phone # of individual who has the authorizing authority to approve or deny the request. A notice regarding an enrollee's appeal rights must also be included in the communication. Plans must have available a "current and accurate online PA process" that provides physicians w/ patient-specific info needed to determine if service is a benefit and info needed to submit request. Online process must provide info required to determine if service is benefit, if PA is necessary and clinical criteria, required	Plans' PA programs must be staffed by health care professionals who are licensed, certified or registered, are in good standing, and must be in the same or related field as the provider who submitted the request, or of a specialty whose practice entails the same or similar covered health care service.	Plan must have extenuating circumstances policy that eliminates the requirement for PA when extenuating circumstance prevents a participating provider from obtaining a required PA before a service is delivered	Specialists must be permitted by insurance carriers and their TPAs to request a PA for a diagnostic or laboratory service based upon advanced review of the medical record.

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WA cont'd	of less intensive service than that included in original request. API or interoperable electronic process for drugs by 2027.				circumstances decisions. Commissioner to release annual report.	appropriateness of service; (d) base determinations on medical info in patient's records and obtained by plan at time of review decisions. Requires workgroup to create standards on PA.					
WV SB 267 (2023) HB 2351 (2019)	Insurer to develop forms and portal. Insurer must accept electronic PA request and respond to requests through electronic means. NCPDP SCRIPT Standard for ePA.	If physician submits request for PA electronically: 5 business days. Urgent: 2 business days Insurer to inform provider of incompleteness in 2 business days. Provider must respond w/in 3 business days or care denied/new request required. Timeframes N/A to PA request submitted through telephone, mail, or fax. Appeals: 10 days			Commissioner to request data on quarterly basis, or more often as needed, to oversee compliance. Data to include, but not be limited to PAs requested, # of PA denied broken down by provider, # of PAs appealed, # of PA approved after appeal, name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation. (PEIA and commercial)	Standard for requiring PA must be science-based using nationally recognized standard. Must use national best practice guidelines to evaluate a PA		One PA per episode of care	Peer review must be w/ provider similar in specialty, education and background.	No PA on Rx at time of inpatient discharge - immediately approved for not less than 3 days (if cost < $5,000/day.) After 3 days, PA may be required. Gold Carding: If provider performed average of 30 procedures/yr in 6-mo period & received 90% approval rating, plan won't require PA for that procedure for 6 mo. Exemption is reviewed before renewal and is subject to internal auditing at any time. Plan may rescind if determines provider isn't performing procedure in conformity w/ requirements based on internal audit.	Medical director has ultimate decision regarding appeal-provider can consult w/ medical director after P2P. Timeframes for P2P appeal process: 5 days from date of request for P2P. If plan wants to audit PA, may be transferred to peer review process w/in 2 business days. Applies to PEIA, Medicaid and commercial health insurers. Commissioner can assess a civil penalty against insurer for violation

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WI		Plan receiving request for PA of experimental procedure that includes all required information upon which to make a decision must issue a decision within 5 working days.									
WY											