2021 Prior Authorization State Law Chart

State	Statute or Reg. or bill	Standard form?	ePA	Response time	PA length and retrospective denial	Disclosure, appeal, and transparency requirements	Qualifications of reviewer	Other provisions	Applies to:
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. When an initial determination not to certify is made prior to or during an ongoing service requiring review, and the physician believes it warrants immediate appeal, the physician can appeal determination via phone on an expedited basis (48 hours).	On appeal, all decisions must be made by a physician in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion as mutually deemed appropriate.		Admission, service, or procedure
AK	7 AAC 120.410 and Alaska Stat. § 21.07.020			Nonemergency:72 hours For care following emergency services: 24 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	Appeals: 18 working days after received. Expedited (jeopardize patient's health): 72 hours.	Decisions to deny, reduce, or terminate a health care benefit or to deny payment for a service because it is not medically necessary must be made by an employee or agent of managed care entity who is a licensed health care provider. On appeal, same professional license as provider.		

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AR	AR Code § 23-99-1107 (2017)	Yes		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 (2) If occurs on a holiday or weekend, plan cannot require notification until the next business day If patient receives emergency care that requires an immediate post-evaluation or post-stabilization service, a plan must make an authorization within 60 minutes of receiving a request.	Cannot rescind, limit or condition based on medical necessity unless provider is notified 3 business days before the scheduled date.	Plans must disclose all PA requirements and restrictions, including any written clinical criteria, in a publicly accessible manner on its website. (If proprietary, can be available via secured link.) Cannot implement new/amended requirements before providing written 60-day notice. Statistics must be available regarding prior authorization approvals and denials on plan's website in a readily accessible format. The statistics must categorize approvals and denials by physician specialty; medication or diagnostic test or procedure; medical indication offered as justification for the prior authorization request; and reason for denial. An adverse determination must be based on medical necessity or appropriateness of the health care services and on written clinical criteria.	An adverse PA determination shall be made by a qualified health care professional	"Medical necessity" includes "medical appropriateness", "primary coverage criteria", and any other terminology used by a plan that refers to a "primary coverage criteria", and any other terminology used by a plan that refers to a determination that is based in whole/in part on clinical justification for a service. The determination by a plan of medical necessity of an emergency service cannot be based on whether the service was provided by an out-of-network provider. If a subscriber's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the subscriber has a terminal illness. A PA decision shall include a determination as to, whether, or not the individual is covered by a health benefit plan and eligible to receive the requested service.	Includes step therapy

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AR Cont.								A provider may submit a benefit inquiry to a plan for a service not yet provided to determine whether the service meets medical necessity and all other requirements for payment.	
AZ	A.R.S. §20-2803			For care provided after initial screening examination and immediately necessary stabilizing treatment, prior auth is granted unless denied or direction of the patient's care is initiated by the plan w/in a reasonable period of time after the plan receives the request	Plan cannot rescind or modify the authorization after the provider renders the authorized 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.	Emergency care
CA	28 CCR § 1300.67 .241	Utilize 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		2 business days for exigent circumstances and 72 hours urgent of receipt of request		Plan must have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical services are consistent with criteria or guidelines that are supported by clinical principles and processes. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, necessity of proposed health care delays, or denies requests by providers to,	Plan must employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.		drugs

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CA Cont.		same manner or another mutually agreeable method.				necessity of proposed health care delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon 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. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).		
CO	C.R.S. 10-16-124.5 C.R.S. 10-16-113	Yes	Electronically means when the provider submits request through a secure, web-based internet portal. Does not include e-mail	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 with		Notice of right to appeal must be given to patient when PA is denied. 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. For prospective review determination, carrier must give provider opportunity to request peer-to-peer conversation regarding adverse determination by the reviewer making determination. Request may be made orally or in writing. Peer-to-peer must occur w/in 5 calendar days of receipt of request and be conducted b/w provider and reviewer who made the determination or a clinical peer designated by reviewer if reviewer can't be available w/in 5 calendar days.			

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CO Cont.				respect to the request and notify the patient and provider within 24 hours.		First level – plan has 30 days. Review 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. Reviewer must consider all comments, documents, records, and other info regarding 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 a licensed physician familiar with standards of care in Colorado. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may sign the written denial.	Can prospectively request peer-to-peer review. Plan must establish a review process at which patient has right to appear in person or by phone at review meeting before a health care professional (reviewer) or, if offered by the plan, a review panel of health care professionals, selected by the carrier. The adverse determination, or w/ respect to a voluntary second level review of a first level review decision, the denial must be reviewed by a health care professional or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person.	Drugs/medical services
CT									
DE	HB 381 (2016)		Yes, NCDPD standard for ePA (no standard 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 the 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.				

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DE Cont.					A PA for a health care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than 60 days from the date the health care provider receives the PA, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered.	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. Clinical criteria must be described in language easily understandable by a provider practicing in the same clinical area. Plans must report statistics on PA approvals, denials, and appeals to the Delaware Health Information Network at least twice annually. Department may also request this data at any time. The statistics shall include: (1) For denials, aggregated reasons for denials; (2) For appeals: a. Practitioner specialty; b. Medication, diagnostic test, or diagnostic procedure; c. Indication offered; d. Reason for underlying denial; and e. Number of denials overturned upon appeal.			Drugs and medical services (not all provisions apply to both.) Not Medicaid
DC									
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)		Yes, 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 healthcare services performed w/in 45 business days of PA, the insurer shall not revoke, limit, condition, or restrict such authorization, except for a Schedule II controlled substance. PA cannot be required of unanticipated emergency services, urgent services, or covered services which are incidental to the primary covered service and determined by the physician or dentist to be medically necessary. New plan must honor old plan's prior auth for 30 days. A change in coverage or approval criteria does not impact patient approval for remainder of plan year.	Clinical criteria on which decision are made must be provided to provider at time of response. Insurers must make aggregate statistics available per such 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.	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 the medical condition or disease; (3) Be knowledgeable of, and have experience providing, the service under appeal; (4) Not have been directly involved in making the adverse determination; and (5) Consider all known clinical aspects of the service under review, including, but not limited to, all pertinent medical or other records provided by the covered person's healthcare provider, any relevant records, and any medical or other literature from provider.	Medical necessity/ necessary: services that prudent provider would provide for purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a 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 the economic benefit of the insurer or for the convenience of patient, treating physician, or other provider; and (d) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan. Violations by plan result in approval of service.	
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.	Approval of covered service cannot be rescinded after the service is provided, except for fraud/ misrep/non-payment of premium, exhaustion of benefits, or member not enrolled at the time service was provided.				

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IL	HB 711 (2021)			nonurgent request in 5 calendar days and 48 hours for urgent care;	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;	15 days for appeal decisions. Denials can be appealed/reviewed by external independent review. 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. 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. An issuer must periodically review requirements and consider removal (1) where a medication or procedure prescribed 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 with an established treatment regimen. Statistical reporting requirements on plans including a list of health care services/drugs subject to prior authorization, total number of prior authorization requests received, total number of denials and the top five reasons for denials, the number of denials appeals and whether they were upheld or reversed, and the average time between submission and response.	The physician reviewing an appeal must: (1) possess a current and valid nonrestricted license to practice medicine; (2) be in the same or similar specialty as a physician who typically manages the medical condition; (3) be knowledgeable of, and have experience providing, the services under appeal; (4) not have been directly involved in making the adverse determination; (5) consider all known clinical aspects of the service under review, including, but not limited to, a review of all pertinent medical records provided to the issuer by provider and any medical literature provided to issuer.	Medically necessary definition: health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with 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 the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome. Clinical review criteria must (1) be based on nationally recognized, generally accepted standards except where State law provides its own standard; (2) be developed in accordance with current standards of a national medical accreditation entity; (3) ensure quality of care and access to needed health care services; (4).	

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IL cont.								be evidence-based; (5) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and (6) be evaluated/updated, if necessary, at least annually. Services are deemed authorized if a plan fails to comply. Payment (generally) if service or drug is authorized	
IN	SB 73 (2017) HR 1143 (2018)	Yes	NCPDP standard. Required of plan and physicians. Exemptions under certain circumstances and provider to use standard form (12/31/2019)	Urgent – 72 hours for determination after receiving request. Nonurgent – 7 business days for determination after request. If incomplete request, must respond w/in time period. (For ePA immediate electronic receipt required.)	After authorization, cannot retroactively deny except if false or incorrect info provided or noncoverage on day of service. Cannot deny claims for unanticipated medical service provided during another authorized medical service based solely on lack of prior auth.	List of prior auth requirements by CPT code on website or portal, including specific information that a provider must submit for request to be completed. Plans must disclose any new prior auth requirements 45 days before implemented (can be accomplished by posted conspicuously on plan's website).			Drugs

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IA	191 IAC 79	Yes	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, the plan may request additional 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.		Payers must make the following available/accessible on websites: a. PA requirements and restrictions, including list of drugs that require PA. b. Clinical criteria that are easily understandable to health care providers, including clinical criteria for reauthorization of a previously approved drug after the PA period has expired. c. Standards for submitting and considering requests, including evidence-based guidelines, when possible, for making PA determinations.			Drugs
KS									
KY	KY Rev Stat § 217.211 SB 54 2019		Insurers must develop, coordinate, or adopt a process for electronically requesting and transmitting PA for drugs that meets the most recent NCPDP SCRIPT standard for ePA adopted by HHS. Fax, proprietary payer portals, electronic forms are not electronic transmission.	Urgent: 24 hours after getting all necessary info. Nonurgent: 5 days after getting all necessary info. Necessary info is limited to the results of any face-to-face clinical evaluation; any second opinion that may be required; and other info determined by the department to be necessary to making a utilization review determination.	PA for a drug for a patient with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, the PA is valid for the lesser of 1 year or the last day of coverage under the plan year. Changes in doses do not require new PA. This provision does not include medications for a non-maintenance condition; that have a typical treatment period <12 months; where there is evidence that does not support 2-month approval; or opioid analgesics or benzodiazepines.	Insurers must make written procedures for determining whether a requested service, treatment, drug, or device is covered; making utilization review determinations; and notifying patients and providers of its determinations readily available on website to covered persons, authorized persons, and providers. Insurers must maintain info on publicly accessible website about list of services/codes for which PA is required including when required (effective dates); date the requirements were listed; and data PA is removed if appliable. Also, must include services where PA is performed by contracted entity. (Cannot deny claim if PA not in effect on data of services on claim)	Any contract entered into on or after the effective date of for the provision of utilization review services, 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.	Medically necessary health care services definition: Health care services that a provider would render to a 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. 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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KY Cont.				The insurer's failure to make a determination and provide written notice w/in the time frames will be deemed to be a PA for the services or benefits subject to the review.		Insurer (or contacted entity), be available to conduct utilization review during normal business hours and extended hours on Monday and Friday through 6:00 p.m., including federal holidays.		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.	
LA	LSA-RS 22:1006 .1 LSA-RS 46:460. 33 LSA-R.S. 22:1139	Yes, must be accessible through multiple computer operating systems.							
ME	Chapter 273 PL S.P. 218- L.D. 705 2019		Must accept/ respond to PA requests through secure electronic transmission using standards adopted by NCPDP for electronic prescribing transactions - fax, proprietary payer portal, or via electronic form is not electronic transmission	Nonemergency: Lesser of 72 hours or 2 business days (notify provider and patient). If does not respond w/ 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.					

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MD	MD Code Ann. 19-108.2	Online process for accepting PA electronically	Plans must establish an online PA system for drugs & for step-therapy		Real time for ePA (pharma) that meets criteria, and no additional info is needed. 1 business day for non-urgent drug; 2 business days non-urgent services (electronically) Unique electronic identifier that provider can use to track PA.	Online access for providers to health care services requiring PA and key criteria for making a determination.		Step-therapy override process	PA and Step therapy
MA	MGL C. 1760, 25	Yes	Must be available electronically	2 business days after receiving a completed PA request from a provider					Rx, provider office visits, imaging/ diagnostic testing, lab testing and any other health care service
MI	Section 500.2212c of the insurance code	For Rx - DOI appoint a workgroup representing insurers, prescribers, pharmacists, hospitals, others in developing PA standard methodology	Workgroup shall consider national standards for ePA developed by NCPDP	15 days for nonurgent, 72 hours for expedited to approve, deny or request more info. After submission of info, time requirements start again. Prescriber must submit additional info w/in 21 days (5 days for urgent)					

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MN	M.S.A. § 62M.05; M.S.A. § 62M.06 M.S.A. § 62M.07 t SF 3204 2019	Yes Sec. 4. MN Statutes 2018, section 62M.04, subdivision 3 limited	Yes, NCPDP standard mandated for prescribers and plans. (If PA for health care service is required, must allow providers to submit requests by telephone, fax, or voice mail or through an electronic mechanism 24 hours a day, seven days a week)	Nonurgent: 5 business days after all info reasonably necessary to make decision is provided (2022) and must provide "audit trail" of notification. Expedited determination required if provider believes warranted. Determination expeditiously as medical condition requires, but no later than 48 hrs and must include at least one business day after the initial request. When expedited adverse determination is made, must also notify the patient and provider of right to submit expedited appeal and the procedure.	When patient changes plans, PA must be good for 60 days. To obtain coverage for this 60-day period, provider/patient must submit documentation of the previous PA to new plan. May not revoke, limit, condition, or restrict a PA that has been authorized 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.	Upon request, provide the provider or patient w/ criteria used to determine necessity, appropriateness, and efficacy of the service and identify the database, professional treatment parameter or other basis for the criteria. UR entity must notify in writing the patient, provider, claims administrator of determination on the appeal w/in 15 days after receipt of the notice of appeal. If the UR entity can't make a determination w/in 15 days due to circumstances outside of its control, may take up to 4 additional days. Anymore and must inform parties of reason. Documentation may include all/part of medical records and written statement from provider. Review of documentation by physician who did not make adverse determination is required. 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.	In cases of appeal to reverse an adverse determination for clinical reasons, the UR organization must ensure that a physician of UR organization's choice in 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.	Definition of clinical criteria: written policies, rules, clinical protocols, medical protocols, or any other criteria or rationale used by the UR entity to determine whether a health care service is authorized. UR org must have written standards: (1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary; (2) system for providing prompt notification of determinations and notifying of appeal procedures; (3) compliance w/ time frames; (4) written procedures to appeal adverse determinations; (5) procedures to ensure confidentiality of patient-specific information, consistent w/ applicable law. Report by 4/1/21 from commissioner to legislature on compliance and additional information from fully and self-insured plans that include total PA request, frequency of electronic requests, response times, reasons for denial, etc.	

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MN Cont.						Plan must post on its public website the PA requirements of org that performs UR review for the plan. If, during plan year, coverage terms change or the clinical criteria used to conduct PA change, does not apply until the next plan year for patients who received PA using former coverage terms or clinical criteria. Does not apply if deemed unsafe, if independent source of research/ clinical guidelines or evidenced-based standards changes for reasons related to patient harm; or if replaced w/ generic rated as equivalent or biologic rates as interchangeable and 60-day notice given. Electronic notice of new/amended requirement must be sent 45 days in advance to all Minnesota-based, in-network attending providers who are subject to the PA requirements.			
MS	MS Code 2015 83-9-63	For drugs; cannot exceed 2 pages	Standard form 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 of obtaining all necessary info. For concurrent review determinations w/in 1 working day of obtaining all necessary info.		A plan must implement a written utilization review program that describes all review activities. A plan must file an annual report of its utilization review program activities with the director. All review programs must use documented clinical review criteria that are based on sound clinical evidence. A plan may develop its own clinical review criteria, or purchase or license clinical review criteria from qualified vendors. A	Any medical director who administers the utilization review program or oversees the review decisions shall be a qualified health care professional licensed in the state of Missouri. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations.	Payer must review entire medical record before a denial of emergency care.	

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MO Cont.						plan must make available its clinical review criteria upon request by regulators. Appeals - 1st level: insurer conducts their own investigation; 2nd level: appeal submitted to an insurer-specific panel for review; 3rd level: insurance director hires appeals review organization.			
MT	Title 33. Insurance and Insurance Companies § 33-36-205.			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.				http://erd.dli.mt.gov/work-comp-claims/medical-regulations/utilization-and-treatment-guidelines	Emergency services and stabilization services.
NE									
NH	NHRSA 420-J;7-b HB 1608 (2017)	Yes	ePA w/NCDPD standard permitted. A payer cannot use ePA when: pharmacist or prescriber (1) lack broadband Internet access; (2) has low patient volume; (3) has opted-out for a certain medical condition or for a patient request; (4) lacks a EMR or when (5) ePA interface does not provide for	48 hours for medically necessary non formulary Rx drug.					

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NH Cont.			the pre-population of prescriber and patient info; (6) ePA interface requires an additional cost to the prescriber.						
NM	NM Stat § 59A-22-52 (2013) SB 188 (2019)	Yes (drugs and services)	No NCPDP Insurers must establish electronic portal system for secure electronic transmission of PA requests 24/7.	7 days Expedited: 24 hours Reasonable medical probability, delay in the treatment could: (a) seriously jeopardize patient's life or overall health; (b) affect patient's ability to regain maximum function; or (c) subject patient to severe and intolerable pain.		By each Sept. each year the office of insurance must provide report to the governor and the legislature to include, at a minimum:(1) PA data for each insurer individually and collectively; (2) the number and nature of complaints against insurers for failure to follow the Act; and (3) actions taken by the office, including imposition of fines, against insurers to enforce compliance. After Dec 31, 2020, insurer may automatically deny PA request electronically submitted and that relates to a drug not on the plan formulary; must provide list of alternative drugs that are on formulary and info on initiating exception request. Insurer must have policies and procedures for annual review of its PA practices to validate the PA requirements advance principles of lower cost and improved quality, safety, and service. Office must establish by rule protocols and criteria by which a patient or health care professional may request expedited	Auto-adjudicated PA request based on medical necessity that is pended or denied must be reviewed by a health care professional who has knowledge or consults with a specialist who has knowledge of the condition or disease of patient. Professional must make a final determination of the request. If request is denied after review by a health care professional, notice of the must include grounds for the denial and a notice of right to appeal and describing the process to file an appeal.	Enforcement: Deemed granted if don't meet turnaround times. Office must keep complaint log against insurers for failure to comply. After 2 warnings, fine <$5,000 for failure to comply.	(includes MCOs)

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NM Cont.						independent review of an expedited PA request following medical peer review of a PA request pursuant to Act.			
NJ									
NY	NY Ins L § 3238 (2012) SB 4721A (2016) http://dfs.ny.gov/insurance/health/ul_min_prior-req.pdf	Yes (take into account NCPDP standards) – Rx	Yes, consider NCPDP standards when developing own	Request info w/in 3 business days and allow 45 days to submit. 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: request info w/in 24 hrs. and allow 48 hrs. to submit. 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. Court ordered treatment – 72 hrs.	Plan must pay claims for a service for which a PA was received prior to rendering of service, unless the enrollee, was not a covered person at the time of care, the submission was not timely under providers' contract, materially inaccurate info submitted, fraud took place, or care related to pre-existing condition that was excluded from coverage.		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)	Step therapy override request must be made within 72 hours of request, and 24 hours for expedited requests	

State	Statute or Reg. or bill	Standard form?	ePA	Response time	PA length and retrospective denial	Disclosure, appeal, and transparency requirements	Qualifications of reviewer	Other provisions	Applies to:
NC	N.C. Gen. Stat. 58-50-61			3 business days after receipt of all necessary information.	Insurer cannot retract determination after services, supplies, or items have been provided, or reduce payments when furnished in reliance on the determination, unless it was based on material misrepresentation about the patient's condition that was knowingly made by patient/provider. N.C. Gen. Stat. 58-3-200(c).	Written notice of a noncertification must be submitted to the provider and the insured, include all reasons for the denial. The notice must include instructions on how to pursue an informal reconsideration, or an appeal (either on expedited or non-expedited basis).	Qualified health care professionals shall administer the UR program and oversee review decisions under the direction of a physician. A physician licensed to practice in North Carolina must evaluate the clinical appropriateness of all noncertifications.	Violations may subject an insurer to enforcement action by Commissioner, which may include civil penalties, restitution, or licensure action.	Health care services (i.e, those provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.).
ND	ND Cent Code 23-01-38		Requires Rx PA to be accessible electronically. Fax is not electronic.						
OH	SB 129 (2016)		Yes, using NCPDP standard for Rx and CAQH operating rules for info exchange in the 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 information.	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. No retroactive denials of a PA assuming medical necessity and eligibility requirement met.	Disclose new PA requirements 30 days in advance. All PA requirements, including documentation requirements, must be posted. Appeals must be between the provider and a clinical peer.	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	Drugs and medical services

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OK	63 OK Stat 63-313B	Use a form for Rx (not standard)						drugs	
OR	OR Rev. Stat. 743.065 and 743.807 and OR Admin. R. 836-053-1200	Standard form – Rx	Must be electronically available	Nonemergency service – 2 business days to notify the prescriber the request is approved; the request is disapproved as not medically necessary or not a covered benefit; missing material information; or the patient is no longer eligible for coverage.	A determination is binding on the insurer for (a) the lesser of 5 business days or the period during which the enrollee's coverage remains in effect, AND (b) The period during which the enrollee's coverage remains in effect beyond the time period established above up to a max of 30 days.	Any denial must be given timely appeal before appropriate medical consultant or peer review committee Only require the minimum amount of material info necessary to approve/disapprove the Rx			
PA									
RI	R23-17.12-UR			15 business days for non-urgent, 72 hours for urgent/emergent. Allow for direct contact with peer reviewer. For non-urgent: 1 business day response. For urgent, reasonable period of time.	A plan cannot retrospectively deny PA for health care services provided when PA has been obtained unless the approval was based on inaccurate info material to the review, or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the PA granted by the review agent.	A first and second level appeal adverse determinations cannot be made until an appropriately qualified and licensed review provider has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician unless physicians choose not to or is not reasonable available.	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	A utilization review agent cannot conduct utilization review for health care services delivered or proposed to be delivered in the state unless the Department has granted the review agent has a certificate. No reviewer will be compensated, paid a bonus, or given an incentive, based on making an adverse determination	
SC									
SD									
TN	§ 56-6-701 et. al.			2 business days within the receipt of request and receipt of all info necessary to complete review.		Initial determinations must follow written clinical criteria set out in statute at 56-6-705. Decision within 30 days or 48 hours (expedited appeal).	Appeal decisions must be made by physician in same or a similar general specialty as typically manages the medical condition.		

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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)	By the 2nd anniversary of adoption of national standards for ePA, a plan must respond via ePA when prescriber initiates a request electronically.			Insurer must provide to any preferred provider a list of services that require PA and info on the PA process w/in 5 business days. Insurer must post PA requirements on website (conspicuously, easily searchable, and w/o needing login) and include: the effective date of the PA requirement; a list of any supporting documentation the plan requires to approve a request; applicable screening criteria, which may include CPT and ICD codes; and statistics on approval/denial rates for the service in the preceding calendar year, including statistics in the following categories: (i)physician or provider type and specialty, if any; (ii)indication offered; (iii)reasons for request 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. (Insurer may, instead of making info publicly available on website that may violate a copyright law or licensing agreement, supply a summary of the w/held info sufficient to allow provider to understand basis for determinations.) Insurer to provide 60-day notice of new or amended PA requirements (5 days if removing PA or making a change that reduces burden on patients/physicians.)	A utilization review agent 's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in the state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in the state. A utilization review agent must conduct utilization review under the direction of a physician licensed to practice medicine in the state.	If noncompliance w/ respect to publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any service affected. Gold carding provision: A physician or provider will receive an exemption from prior authorization for a service from a plan if, in a 6-month period, receive 90% approvals for prior auth requirements for that service.	Medical care or health care services

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TX Cont.						Before an adverse determination is issued based on medically necessity, the appropriateness or experimental or investigation nature of service, provider who requested, provided or will provide the services must be offered reasonable opportunity to discuss treatment plan and clinical basis for determination w/ a physician licensed to practice medicine. If w/in 10 working days after the date an appeal is requested or denied, the provider requests a particular type of specialty provider review the case, a provider who is of the same or a similar specialty as the provider who would typically manage the condition, procedure, or treatment under consideration for review shall review the denial or the decision denying the appeal. The specialty review must be completed w/in 15 working days of the date the request for specialty review is received. Must allow expedited appeal for denial of emergency care, continued hospitalization, or if requesting provider includes a written statement w/ supporting document s that service is necessary to treat life-threatening condition or prevent serious harm to patient. Must include review by provider who has not previously reviewed the case; and is same or a similar specialty of provider who typically manages the condition/procedure/treatment.			

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UT									
VT	18 VSA 9418b.	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 with medical services only.)	Plan must accept the national standard transaction information, 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.					drugs, medical procedures, and medical tests
VA	SB 1262 (2015) S1607 2019		Yes, NCPDP standard	Plan must notify the provider after submission of complete request w/in 24 hours (including weekend hours) for urgent, 2 business days for non-urgent. Tracking system should be available. 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 supplementation.	PA granted by another plan be honored for at least initial 30 days of members' new Rx coverage. Must honor PA for a drug, other than an opioid, regardless of changes in dosages. Must honor PA issued by the insurer regardless, if enrollee changes plans, with the same insurer and the drug is a covered benefit with the current health plan.	Plan's formularies, PA requirements and request forms must be available on plan's website and updated w/in 7 days of changes.		Stakeholders to convene workgroup to look at common evidence-based parameters for carrier approval of 10 most frequently prescribed chronic disease management drugs subject to PA by a majority of carriers, 10 most frequently prescribed mental health prescriptions subject to PA by a majority of carriers, and generic prescription drugs subject to PA by a majority of carriers.	drugs

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VA Cont.					If during a previously authorize invasive or surgical procedure the 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, but medically necessary as a covered service under plan; (ii) appropriately coded; and (iii) compliant with post-service claims process, including required timing for submission.			PAs approved by another insurer are honored for drug for at least initial 30 days under new plan, subject to the provisions of the new carrier's evidence of coverage,. Require an insurer, when requiring a prescriber to provide supplemental info that is in the covered individual's health record or electronic health record, to identify the specific info required.	
WA	**SB 5346 CR-103**	Requires workgroup to create standards on PA. Starting 11/19, plans must have available a "current and accurate online PA process" that provides physicians w/ patient-specific info needed to determine if a service is a benefit and info needed to submit complete request.	Must have a secure online process and ability to upload documentation when required.	Non-urgent: 5 days Expedited: 2 days Plans must allow a provider or facility to submit a request for a PA for a service at all times, including outside normal business hours. If these timelines are not sufficient, see "extenuating circumstances" policy. No PA required in emergency situations.	PA cannot expire sooner than 45 days from date of approval	Denial must include specific reason and if based on clinical review criteria, the criteria must be provided. A denial must include the department, credentials and phone number of the 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. Approval notice must state if service may be delivered by an out-of-network provider and if so, disclose to the patient financial implications for receiving services from an out-of-network provider or facility. Plan must maintain a documented PA program description and use evidence based clinical review criteria. Online process must allow provider access to clinical criteria.	Insurance carriers' 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 a PA of services when extenuating circumstance prevents a participating provider or facility from obtaining a required PA before a service is delivered. Plan must (a) Accept any evidence-based info from provider that will assist in the process; (b) Collect only the info necessary to authorize the service and maintain a process for the provider to submit records; (c), require only the section(s) of the medical	Medical services (not Rx) for individual (both on and off the exchange), small group, large group – excludes Medicaid (MMC and FFS), Medicare, Taft-Hartley, PEBB/Uniform Medial ad TRICARE

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WA Cont.		Online process must provide info required to determine if service is a benefit, if PA is necessary, what if any preservice requirements apply, and if PA is required, clinical review criteria and any required documentation				Insurance carriers and their TPAs must give providers 60-days prior notice before making any changes to its prior authorization program, including the addition of new PA requirements to services or changes to the clinical criteria used to consider PA requests.		record necessary to determine medical necessity or appropriateness of the service; and (d) Base determinations on the medical info in the patient's records and obtained by plan at time of the review decisions. 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.	
WV	HB 2351 (2019)	Insurer to develop forms and portal.	Insurer must accept electronic PA request and respond to requests through electronic means by 7/1/20. NCPDP SCRIPT Standard for ePA.	If physician submits request for PA electronically and all info is provided: 7 days. If delay could seriously jeopardize life, health or safety of patient or subject patient to adverse health consequence in opinion of provider: 2 days Insurer to inform provider of incompleteness in 2 business days. Provider must respond w/in 3 business day or care denied/new request required. Timeframes N/A to PA request submitted through telephone, mail, or fax.	PA carriers to MCOs, health insurers and public employees insurance agency for 3 months if provided in state.	Form must include instruction for submitting clinical info; an electronic notification confirming receipt of PA request if forms are submitted electronically; list all services, drugs, devices that require PA (updated quarterly). Medical director has ultimate decision regarding appeal determination and provider can consult w/ medical director after peer-to-peer. Timeframes for appeal no longer than 30 days.	Peer review must be w/ provider similar in specialty, education and background.	One PA for episode of care. Standard for requiring PA must be science-based using nationally recognized standard. Must use national best practice guidelines to evaluate PA. If step-therapy required, must be on PA form. Gold Carding: If provider has performed an average of 30 procedures/year and in 6-month time period has received a 100% prior approval rating, insurer won't require provider to submit a PA for that procedure for the next 6 months. At end of 6 months, exemption is reviewed before renewal. Subject to internal	Includes Public Employees Insurance Agency, MCOs, Health care corporations, HMOs Medication and services

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WV cont.				Any prescription for an inpatient at time of discharge requiring a PA will not be subject to requirements and be immediately approved for not less than 3 days (if cost < $5,000/day. After 3 days, PA required.				auditing at any time by insurer and may be rescinded if insurer determines provider is not performing procedure in conformity w/ the insurer's benefit plan based upon the results of internal audit.	
WI	632.85							No PA for emergency services. Secretary of Children and Families created a prescription drug prior authorization committee to advise department on issues related to PA decisions made concerning drugs on behalf of medical assistance recipients.	
WY									