2018 Prior Authorization State Law Chart

State	Statute or Reg. or bill	Standard form?	ePA	Response time	PA length and retrospective denial	Disclosure and appeal	Qualifications of reviewer	Other provisions	Applies to:
AL	Ala. Code 1975 § 27-3A-5			2 business days		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	Act 815	Yes		72 hours	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.	Includes step therapy

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AR Cont'd								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. 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			Within a reasonable period of time after the plan receives the PA 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.	
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		2 business days 72 hours urgent		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 necessity of proposed health care 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, delays, or denies requests by providers prior 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		drugs

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CA Cont'd		agreeable method. Notices to provider delivered in same manner or another mutually agreeable method.				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.	of health care services to enrollees, complies with the requirements of this section. 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 covered person to extend the course of treatment beyond the initial period of time		Notice of right to appeal must be given to covered person when PA is denied Must disclose list of drugs that require PA, written clinical criteria and criteria for reauth of a previously approved drug after PA period expired. Evidence based guidelines. In a case involving a prospective review determination, a carrier shall give the provider rendering the service an opportunity to request on behalf of the covered person a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing. The peer-to-peer conversation shall occur within 5 calendar days of the receipt of the request and shall be	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 the covered person has the right to appear in person or by telephone conference at the 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 with respect to a voluntary second level	Drugs/medical services

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CO Cont'd				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 carrier shall make a determination with respect to the request and notify the covered person and the covered person's provider within 24 hours.		conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within 5 calendar days. First level – plan has 30 days. Review must be evaluated by a physician who consults with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. Reviewer must consider all comments, documents, records and other info regarding the request submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.		review of a first level review decision, the denial shall be reviewed by a health care professional (reviewer) 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.	
CT									

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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. 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									

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FL	Ch. 2016-224 (627.42392) and Ch. 16 – 222	A plan that does not use ePA for a contracted provider must use the standard PA form approved by the FSC							
GA	GA Code Ann. 33-64-8		Yes, NCPDP standard						
HI		General form used by some insurers							
ID	Title 41, Ch. 39 (41-3930)			2 business days, 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				
IL	215 ILCS 134			72 hours; 24 hours expedited	Approval of medical exception request good for one year or end of coverage.	15 days for appeal decisions. Denials can be appealed and reviewed by external independent review. Must provide, upon request, pre-certification and other utilization review procedures and requirements	As provided in the IL Health Carrier External Review Act	Medical exception process, includes step therapy exceptions process – 72 hours for a decision.	drugs
IN	SB 73 (2017)		Yes, NCPDP standard						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 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		W/in 24 months of NCPDP national standards for ePA being available, agencies promulgating regs re: e-prescribing must consider ePA standards						

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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									
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

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MA	MGL C. 1760, 25	Yes	Must be available electronically	2 business days					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 - Commissioner appoint a workgroup representing insurers, prescribers, pharmacists, hospitals, and others in the development of a standard PA methodology	Workgroup shall consider national standards for ePA developed by NCPDP	15 days 72 hours for expedited					
MN	M.S.A. § 62M.05 ; M.S.A. § 62M.06 M.S.A. § 62M.07 t	Yes	Yes, NCDPD standard mandated for prescribers and plans	10 business days. When not certifying, notification must be provided by phone, fax or email in 1 working day after determination provided. Expedited initial determination to certify must be provided as expeditiously as medical condition requires, but more than 72 hours from the initial request.		With decision to not certify, written notification must inform the enrollee provider of the right to appeal in a culturally and linguistically appropriate manner. Enrollee can review info, present evidence and testimony, and receive continued coverage pending the outcome of appeals process. 30-days for standard appeal, 72-hours for expedited			

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MS	MS Code 2015 83-9-63	For drugs; cannot exceed 2 pages	Standard form must be available electronically	2 business days					
MO	Mo stat. 376.1350 - 376.1389			36 hours, 1hour for post-stabilization emergencies.		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 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	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.		
MT	Title 33. Insurance and Insurance Companies § 33-36-205.			No PA for emergency care. 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

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NE									
NH	NHRS A 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 an EMR; or when (5) ePA interface does not provide for the pre-population of prescriber and patient info; (6) ePA interface requires an additional cost to the prescriber.	48 hours for medically necessary non formulary Rx drug					

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NJ									
NM	NM Stat § 59A-22-52 (2013)	Yes for Rx	Available after national standards are set	3 days (with form)					
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	3 business days	Plan must pay claims for a service for which a PA was received prior to the 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	

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NC	N.C. Gen. Stat. 58-50-61			3 business days after receipt of all necessary information.	Insurer cannot retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on the determination, unless it was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the 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 an M.D. An M.D. licensed to practice in North Carolina shall 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.), but not emergency services satisfying prudent layperson standard.
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	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. 836-053-1205	Standard form – Rx	Must be electronically available	Nonemergency service – 2 business 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	HB 1293 (proposed 2017)								
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 chooses 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									

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SD									
TN	**§ 56-6-701 et. al.**			2 business days		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.		
TX	TX Ins. Code 1369.304 and TX Admin Code 19.1820	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.						
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	48 hours – urgent; 120 hours – non urgent					drugs, medical procedures, and medical tests

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VA	SB 1262 (2015)		Yes, NCPDP standard	24 hours for urgent, 2 business days for non-urgent. Tracking system should be available.	PA granted by another plans be honored for at least initial 30 days of members' new Rx coverage.	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 the 10 most frequently prescribed chronic disease management prescription drugs subject to prior authorization by a majority of carriers, the 10 most frequently prescribed mental health prescription drugs subject to prior authorization by a majority of carriers, and generic prescription drugs subject to prior authorization by a majority of carriers.	
WA								A plan must have an extenuating circumstances policy that eliminates the administrative requirement for a PA of services when an extenuating circumstance prevents a participating provider or facility from obtaining a	

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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 with patient-specific info needed to determine if a service is a benefit under the enrollee's plan and the info needed to submit complete request. Online process must provide info required to determine if the service is a benefit, if PA is necessary, what if any preservice requirements apply, and if a PA is required, clinical review criteria and any required documentation	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 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.	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 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.	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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WV									
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									