2022 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 (jeopardize patient's health): 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	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.		Cannot rescind, limit, condition based on medical necessity unless provider notified 3 business days before scheduled date. 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. 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, including any written clinical criteria, in a publicly accessible manner on website. (If proprietary, can be available via secured link.) 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 prescription pain medication requires PA, then PA can't be denied if patient has terminal illness.	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.
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.					.

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CA 28 CCR § 1300.67.2 41	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.				Every plan using step therapy (ST) and PA must maintain, for at least 10 yrs. info to be made available to department upon request re: nonformulary drug requests, ST exceptions request and PA: (1) #of requests (2) Type of providers/ 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 and approval (7) #of denials by type of provider and specialty.						

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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											
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 statistics on PA approvals, denials, appeals to the DHIN at least twice annually. Department may also request data at any time. Statistics must include: (1) For denials, aggregated reasons for denials; (2) For appeals: a. specialty; b. Medication, diagnostic test, or diagnostic procedure; c. Indication offered; d. Reason for underlying denial; and e. # of denials overturned upon 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.			
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, the insurer may not revoke, limit, condition, or restrict authorization, except for a Schedule II controlled substance. When physician receives 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 prescribed		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	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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GA cont'd			during the period of authorization. New plan must honor old plan's PA for 30 days.						provider, relevant records, and medical or other literature from provider		
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 HB 711 (2021)		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	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	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 (1) be based on nationally recognized, generally accepted standards except where IL law provides own standard; (2) be 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)be evidence-based; (5) be sufficiently flexible to allow deviations from norms on a case-by-case basis; and (6) be	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	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;	Denials can be appealed/ reviewed by external independent review.

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IL cont'd			Continued approval when plan's requirements change	service or drug is authorized		updated, if necessary, at least annually. "Medically necessary:" 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 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.			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.	or (2) for patients currently managed w/ established treatment regimen.	
IN SB 73 (2017) HR 1143 (2018)	NCPDP standard. Required of plan and physicians. Exemptions under certain	Urgent – 72 hours Nonurgent – 7 business days. If incomplete request, must respond w/in time period. (For ePA		If authorized, cannot retroactively deny, except if false or incorrect info provided or			Plans must disclose any new PA requirements 45 days before implemented (can be posted	List of PA requirements by CPT code on website or portal, including specific info that must be submitted.			

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	circumstances & provider to use standard form	immediate electronic receipt required.)		noncoverage on day of service. Cannot deny claims for unanticipated medical service provided during another authorized service based solely on lack of PA.			conspicuously on plan's website).				
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 must pay provider at contracted rate for a service per the PA unless: 1. Waste, fraud or abuse 2. Provider/ patient provided inaccurate info that was relied upon to make the authorization 3. Service was no longer a benefit on the day it was provided 4. Care provided was no longer contracted with the plan on the date the care was provided 5. Provider failed to meet plan's timely filing requirements.				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.			

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IA cont'd				6. Plan does not have liability for a claim (coordination of benefits) 7.Patient was no longer eligible							
KS											
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 after getting all necessary info. Nonurgent: 5 days after getting all necessary info. Necessary info is limited to 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 determination. 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.	PA is valid for lesser of 1 yr or last day of coverage when Rx is for patient w/ a condition requiring ongoing medication therapy, and the provider continues to prescribe the drug. Changes in doses do not require new PA. Does not include drugs for a non-maintenance condition; that have a typical treatment period <12 months; where there is evidence that	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	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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KY cont'd			does not support 12-month approval; or opioid analgesics/be-nzodiazepines					is performed by contracted entity.			
LA 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.							Plans must furnish in writing, w/in 24 hours of written/ oral request by provider or patient, medical criteria and other requirements for authorization. Upon denial, plan must provide written notification of denial and info on applicable law, regulation, policy, procedure, or medical criterion or guideline.		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)	

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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.									
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 from a provider									
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,		Every year, plan must report to department on department, aggregated trend data related to their PA practices and	PA requirements to be based on peer-reviewed clinical review criteria developed either by (1) entity that works directly w/ clinicians (in or outside plan) to develop clinical review	For drugs, plan must notify providers via plan's provider portal of new or amended PA requirements at least 45 days before implemented. For	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	Plans must adopt a program that promotes the modification of PA requirements of certain	

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MI cont'd			whichever is later.		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.	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.	services, must notify at least 60 days before implemented.		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.	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.	
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	Nonurgent: 5 business days after all info reasonably necessary to make decision is provided and 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 adverse determination is	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		Electronic notice of new/amended requirement must be sent 45 days in advance to all MN-based, in-network attending providers who are subject to requirements. If, during plan year, coverage terms change or the clinical criteria used to conduct PA change, does not apply until the next	Upon request, plans must provide criteria used to determine necessity, appropriateness, and efficacy of service and identify the database, professional treatment parameter or other basis for the criteria.	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		

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MN cont'd	through an electronic mechanism 24 hours/day, 7 days/week Standard form: Sec. 4. MN Statutes 2018, section 62M.04, subdivision 3 limited	made, must also notify patient and provider of right to submit expedited appeal. Plan 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 plan entity can't make a 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.			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.		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.	Plan must post on its public website PA requirements of organization that performs UR review for the plan. 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 adverse determinations; (5) procedures to ensure confidentiality of patient info.	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.		
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.									

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MO Mo stat. 376.1350 -376.1389 SB 982 (2018)		2 business days after obtaining all necessary info. For concurrent review determinations, w/in 1 working day of obtaining all necessary info				All review programs must use documented clinical review criteria that are based on sound clinical evidence. Plan may develop its own clinical review criteria, or purchase or license clinical review criteria from qualified vendors. Plan must make available its clinical review criteria upon request by regulators.		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 adverse determinations.		Appeals: - 1st level: insurer conducts investigation; -- 2nd level: submitted to an insurer-specific panel for review; -3rd level: insurance director hires appeals review organization.
MT § 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.									
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. Plan must make criteria 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		

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NH NHRSA 420-J;7-b	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				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.					
NM NM Stat § 59A-22-52 (2013) SB 188 (2019)	Standard form- drugs and services Plans must establish electronic portal system	7 days Expedited: 24 hours (Reasonable medical probability, delay a in treatment could: (a) seriously jeopardize patient's			By every Sept., OSI to report to Governor/legislature minimum:(1) PA data for each plan individually and collectively; (2) the number and nature						

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NM cont'd	for secure electronic transmission of PA requests 24/7	life or overall health; (b) affect patient's ability to regain maximum function; or (c) subject patient to severe and intolerable pain.)			of complaints against plan for failure to follow the Act; and (3) actions taken by the office, including fines, against plans to enforce compliance.						
NJ P.L. 2005, C. 352 www.state.nj.us/dobi/chap352/352uminitialqanda.html#q2		Generally, 15 days request. When patient receiving inpatient hospital services, plan respond w/in 24 hours.		If a plan grants PA for a service, or approves it upon concurrent review, plan cannot make a retrospective review and deny coverage based on medically necessity in the absence of fraud or misrepresentation		"Medically necessary" means a health care service that a health care provider, exercising his prudent clinical judgement, would provide.for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance w/ the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent site and duration, & considered effective for patient's illness, injury or disease; not primarily for convenience of 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.	Changes in any UM standards must be posted on website at least 30 days prior to the change becoming effective.	Plan must identify the commercial company that produced clinical guidelines used in determining medical necessity. Plan must post a copy of all internally-produced clinical criteria used to determine medical necessity. All info must be posted in a clear and conspicuous manner.	Any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a physician under the clinical direction of the medical director who shall be licensed in NJ.		Provider does not have independent right to appeal an adverse determination but plans may allow. In order to appeal to Stage 3 at the Independent Health Care Appeals Program (IHCAP), provider must have consent from the patient.

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NY NY Ins L § 3238 (2012) SB 4721A (2016) 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. 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		Plan must pay claims for service for which PA was received prior to care, unless patient was ineligible at time of care, claim was not timely, inaccurate info submitted, or fraud. When providing service, if provider determines additional/related service is immediately necessary, and in clinical judgment is a medically timely service and would not be advisable to interrupt provision of care for a PA, plan cannot deny payment unless service was (1) not covered benefit (2) not medically necessary; (3)investigational /experimental; (4) see above factors re: permitted denials.					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)		

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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 cannot retract determination after services, supplies, or items provided, or reduce payments when furnished in reliance on determination, unless it was based on material misrepresentation re: patient's condition that was 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 ND Cent Code 23-01-38	Rx PA to be accessible electronically. Fax is not electronic.										
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	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	No retroactive denials of a PA assuming medical necessity and eligibility requirement met. Upon written request, plan must permit a retrospective review for service where PA was required but not obtained if service was (i)			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.	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

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OH cont'd	NCPDP standard.		indicating that the patient's chronic condition has not changed not more than quarterly. (Provider must respond w/in 5 days.)	directly related to another service for which PA has been obtained and performed; (ii) service was not known to be needed when original service was performed and (iii) need for service was revealed when original service was performed. Plan cannot deny claim for such a service based solely on the fact that a PA approval was not received.				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.			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, practitioner may resubmit the claim.
OK 63 OK Stat 63-313B	Use a form for Rx (not standard)										
OR HB 2517 (2021)	Standard form for Rx. Must be electronically available Provider can make a secure electronic submission, meeting industry standards for	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.	Approved PA, (not Rx), is binding on plan for the later of: (A)reasonable duration of treatment based on clinical standards; or (B)60 days after the date	Except in the case of misrepresentation 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	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	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	Plan to post on website requirements for requesting coverage of a treatment, drug, device, diagnostic or laboratory test subject to utilization review, including specific documentation	Plans must use OR-licensed physician to make all final recommendations regarding coverage for care subject to utilization review and to consult as needed.	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

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OR cont'd	privacy, along with needed documents, and receive an electronic acknowledge-ment of receipt of request.		that treatment begins following approval of PA. For Rx: 1 yr from date treatment begins following approval if drug: (A)is prescribed as maintenance therapy expected to last at least 12 months based on medical or scientific evidence; (B) prescribed throughout the 12-month period.		info requested by plans; (C) # of requests that were initially approved; and (D) # of denials that were reversed by internal appeals or external reviews.	treatment.	provide coverage of the treatment until utilization review, internal and external reviews are completed.	required, and a list of the treatments, drugs, devices or diagnostic or laboratory tests 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.	For IRO, at least one reviewer must be a clinician in same or a similar specialty as the provider who prescribed the treatment.		telephone responses to inquiries concerning certification of continued length of stay.
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.	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	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	Licensed health care provider w/ appropriate training, knowledge or expertise in same/similar specialty or, licensed health care provider in consultation w/ appropriately qualified 3rd-party health care		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

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PA cont'd	Plans have to offer training for providers. Providers must us portal to submit PA request (some exceptions).					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.		specified in the law that outlines right to an appeal and external appeal.	provider, licensed in same/similar specialty or type of provider who manages condition. Internal and external grievance process for Medicaid/CHIP MCOs - licensed physician in same/similar specialty that typically manages or consults on service. IRO review for commercial plans-physician or appropriate provider w/ expertise in treatment of condition and has recent or current actual clinical experience.		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).
RI 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.		A utilization review entity cannot retrospectively deny authorization for				A utilization review agent cannot conduct utilization review for services delivered or	All initial, prospective and concurrent adverse determinations and all first level		A first and second level appeal adverse determinations cannot be made until an

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RI cont'd				services provided when PA was obtained unless approval was based on inaccurate info material to the review, or services were not provided consistent w/ submitted plan of care and/or any restrictions included in the PA granted by the review agent.				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.	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		appropriately qualified and licensed review provider has spoken to, or otherwise provided for, an equivalent two-way direct communication with patient's attending physician unless physicians choose not to or is not available.
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. Appeals: 30 days Expedited appeals: 48 hours Plans must make staff available by toll-free telephone at least 40 hours/week during normal business hours and have a telephone system capable of accepting or recording incoming telephone calls during other than							Physicians or psychologists making determinations must have current licenses from a state licensing agency in US. Appeals: adverse decisions must be made by physician in same or a similar general specialty as typically manages the		

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TN cont'd		normal business hours and shall respond to these calls within 2 working days;							medical condition. For mental health and SUD care, person performing the review in appeal must be both licensed at independent practice level and in appropriate mental health or chemical dependency discipline like that of the requesting provider.		
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	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; (ii)indication offered; (iii)reasons for denial; (iv)denials overturned on internal appeal; (v) denials overturned by an independent review org; (vi)		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.)	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 (conspicuously, easily searchable, and w/o needing login) and include: the effective date of PA requirement; a list of any supporting	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 w/ input from appropriate health care providers and approved by a	Gold carding: 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.	Before adverse determination based on medically necessity, appropriateness or experimental or investigational nature of service, provider must be able to discuss w/ a physician licensed to practice medicine. If w/in 10 working days after date an appeal is requested or

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TX Cont'd	via ePA when prescriber initiates a request electronically.				total annual PA requests, approvals, and denials for service			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.	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.		denied, the provider requests a particular type of specialty provider review, a provider who is of the same or a similar specialty must review the denial or the 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.	A plan using PA must report to department, for previous calendar year, the 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 PA determination request by physician based on clinical or medical necessity may only be reviewed by a physician currently licensed in state, district, or territory of US. Appeal of adverse determination based on clinical or medical necessity of a drug, may only be reviewed by individual currently licensed in a state, district, or territory US as a physician and 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	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									

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VT cont'd	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	receipt of the request for prior auth and any needed missing information within 24 hours of receipt.									
VA SB 1262 (2015) S1607 2019	ePA requirements using NCPDP standard	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. Plan must notify the provider after submission of complete request w/in 24 hours (including weekend hours) for urgent, 2	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	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				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	

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VA cont'd		business days for non-urgent. Tracking system should be available.	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.	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.						management drugs subject to PA, 10 most frequently prescribed mental health prescriptions subject to PA, and generic prescription drugs subject to PA.	
WA SB 5346 CR-103	Must have a secure online process and ability to upload documents.	Non-urgent: 5 days Expedited: 2 days Plans must allow a provider to submit a request for a PA for a service at all times, including outside normal business hours.	PA cannot expire sooner than 45 days from date of approval			Plan must maintain a documented PA program description and use evidence based clinical review criteria. Online process must allow provider access to clinical criteria. 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	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	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						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. Requires workgroup to create standards on PA.		"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, preservice requirements apply, if PA is required, clinical criteria, any required			
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	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				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	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

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WV cont'd	Standard for ePA.	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.								procedures/yr in 6-mo period & received 100% 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.	
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											