



North Dakota Legislative Council

Prepared for the Health Care Committee
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ELECTRONIC PRIOR AUTHORIZATION REQUIREMENTS - BACKGROUND MEMORANDUM

Section 3 of Senate Bill No. 2280 (2025) ([appendix](#)) provides for a study of the ability for health care systems and providers to submit prior authorization reviews for nonurgent and emergency health care services by secure electronic means. The study must analyze alternatives to facsimile or mail for transmitting prior authorization requests and supporting medical records. The study must include input from stakeholders, including patients, providers, and commercial insurance plans.

BACKGROUND

Prior authorization is the review conducted before the delivery of a health care service to evaluate the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person other than the attending health care professional, for the purpose of determining the medical necessity of the health care services or admission.¹ Prior authorization includes a review conducted after the admission of the enrollee and in situations in which the enrollee is unconscious or otherwise unable to provide advance notification.

Testimony from insurers on Senate Bill No. 2280 indicated the need to study electronic submission to provide timely care to patients due to receiving over one-third of prior authorization requests through facsimile transmission, rather than electronic, and additional handwritten submissions.

NORTH DAKOTA STATUTORY PROVISIONS

The North Dakota Century Code includes various provisions relating to prior authorization. However, few expressly relate to electronic transmission. Section 23-01-38 requires drug prior authorization requests to be accessible to a health care provider within the provider's electronic prescribing software system and to be accepted electronically, through a secure electronic transmission, by the payer, the insurance company, or the pharmacy benefit manager responsible for implementing or adjudicating the authorization or denial of the prior authorization request.

FEDERAL LAW

In February 2024, the federal Centers for Medicare and Medicaid Services (CMS) issued the CMS interoperability and prior authorization final rule. The final rule emphasizes the need to improve health information exchange to achieve appropriate access to health records and focuses on efforts to improve the prior authorization process through policies and technology. The final rule became effective in April 2024, with the initial requirements of the rule to be met by health insurance plans governed by CMS by January 1, 2026, and all remaining requirements to be met by January 1, 2027. The health insurance plans governed by CMS include Medicare Advantage organizations, state Medicaid fee-for-service programs, Medicaid managed care plans, state children's health insurance fee-for-service programs, children's health insurance managed care entities, and qualified health plan issuers on the federally facilitated exchanges.²

These payers must implement and maintain a Prior Authorization API, an application program interface, to improve the electronic exchange of health care data. Providers must be able to use the Prior

¹ NDCC § 26.1-36.12-01.

² See 89 Fed. Reg. 8758 (February 8, 2024).

Authorization API to determine whether a specific payer requires prior authorization for a certain item or service and identify what documents are required for prior authorization approval. The Prior Authorization API must communicate whether a prior authorization is approved, denied, or if more information is requested. The rule also permits patients, through health applications of their choice, to be able to access their claims and information, including laboratory results, provider remittances, and patient cost-sharing for claims through a Patient Access API. Impacted payers also must include information about certain prior authorizations through the Patient Access API.

ADJACENT STATES

South Dakota and Montana

South Dakota has few requirements for prior authorizations and no express requirements for prior authorizations to occur by electronic submission. Statutory and regulatory references to submission format provide that prior authorizations may be submitted in written or electronic form. Montana similarly has no express requirements for electronic submissions.

Minnesota

In Minnesota, if prior authorization is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, 7 days a week.³ Each health plan company must post on its public website the number of authorization requests that were submitted electronically and not by facsimile, email, or other method.⁴ When a determination is made to authorize, notification must be provided promptly by telephone to the provider. Notification also may be made by facsimile to a verified number or by email to a secure electronic mailbox.⁵ When an adverse determination is made, notification must be provided in the same manner with additional written notification to the provider and enrollee.⁶

OTHER STATES

Arkansas

In Arkansas, a utilization review entity must implement a mechanism in which health care providers may request prior authorizations through an automated electronic system as an alternative to telephone-based prior authorizations.⁷ The health care provider retains the ability to use either the automated system or telephone-based system. The automated system must be capable of handling benefit inquiries by health care providers before providing a service to determine whether a service meets medical necessity or other requirements under the plan, if the service were to be provided to a specific plan member. A utilization review entity also may use a single standardized prior authorization form only, either written or electronic, for prescription drug benefits.⁸ The form must be designed to be submitted electronically.

District of Columbia

In the District of Columbia, for health services that are nonurgent or related to long-term services or supports, if a prior authorization is required, a utilization review entity must make a determination within 3 business days if the request was submitted through an electronic portal in contrast to 5 business days for requests submitted through mail, telephone, or facsimile.⁹

Indiana

In Indiana, a utilization review entity must accept a request for prior authorization submitted by a covered individual's health care provider through a secure electronic transmission or an application

³ Minn. Stat. § 62M.07 (2025).

⁴ Minn. Stat. § 62M.18 (2025).

⁵ Minn. Stat. § 62M.05 (2025).

⁶ *Id.*

⁷ Ark. Code Ann. § 23-99-1109 (2025).

⁸ Ark. Code Ann. § 23-99-1117 (2025).

⁹ D.C. Code § 31-3875.03 (2025).

programming interface.¹⁰ A health care provider must submit the request through these electronic methods. The utilization review entity must provide for the secure electronic transmission or an application programming interface and must acknowledge receipt of each request by issuing a transaction number or code. These requirements do not apply to prior authorizations of prescription drugs. The requirements also do not apply if the utilization review entity and health care provider enter an agreement to process prior authorizations through nonelectronic methods because electronic requests would cause financial hardship for the health care provider, the area in which the health care provider is located lacks sufficient Internet access, or the health care provider has insufficient covered patients to warrant the financial expense to comply with electronic prior authorizations.

Kentucky

In Kentucky, an insurer must have, on or before January 2020, developed, coordinated, and adopted a process for electronically requesting and transmitting prior authorizations for a drug.¹¹ This process must be accessible by providers. Facsimile, proprietary payer portals, and electronic forms are not considered electronic transmission.

Maryland

In Maryland, an insurer must, on or before July 1, 2026, establish and maintain an online process that can accept electronic prior authorization requests from a health care provider and can approve electronic prior authorization requests for which no additional information is needed by the carrier to process the request, no clinical review is required, and which meets the insurer's criteria for approval.¹² An insurer may not impose a fee or charge for accessing the online process and may not access health care provider data other than for the specific insured individual. The insurer must provide the contact information of each third-party vendor used to meet the electronic requirements upon the request of a health care provider and must post this information to its website.

New Mexico

New Mexico requires a health insurer that offers prior authorization to create and maintain an electronic portal system.¹³ Secure electronic transmission of prior authorization requests must be available every day, 24 hours a day, for medical care, pharmaceutical benefits, or related benefits. The system also must provide for auto-adjudication of prior authorization requests. Health insurers also must provide an electronic receipt and assign and provide a tracking number to health care providers for prior authorization requests. Health insurers must auto-adjudicate all electronically transmitted prior authorization requests to approve or pend a request for benefits. An insurer may automatically deny a covered person's prior authorization request that is electronically submitted and that relates to a prescription drug that is not on the covered person's health benefits plan formulary, provided the insurer accompanies the denial with a list of alternative drugs that are on the covered person's health benefits plan formulary. Health insurers must otherwise accept requests that are not electronically submitted for medical care, pharmaceutical benefits, or related benefits. Health insurers also must establish a process for health care providers or covered persons to initiate an electronic appeal of a denial of a prior authorization request.

Oregon

In Oregon, a health insurer must have a website where a provider can make a secure electronic submission or a request for coverage of a treatment, drug, device, or diagnostic or laboratory test that is subject to utilization review, along with needed forms and documents, and receive an electronic acknowledgement of receipt of the request.¹⁴

¹⁰ Ind. Code § 27-1-37.5-10 (2025).

¹¹ Ky. Rev. Stat. § 304.17A-167 (2025).

¹² Md. Code, Health-Gen. § 19-108.5 (2025).

¹³ N.M. Stat. Ann. § 59A-22B-5 (2025).

¹⁴ Or. Rev. Stat. Ann. § 743B.423 (2025).

Tennessee

In Tennessee, an insurer or utilization review organization must accept and respond electronically to prior authorization requests from a health care provider submitted through a secure electronic transmission, as determined by the insurer or utilization review organization. If a prior authorization for a prescription drug is submitted electronically using the National Council for Prescription Drug Programs SCRIPT Standard for electronic prior authorization transactions, the insurer or utilization review organization must accept and respond to the prior authorization request using the same method of transaction. A health care provider is not required to submit prior authorizations electronically.¹⁵

West Virginia

In West Virginia, a health insurer must require prior authorization forms to be submitted through an electronic portal and must accept one prior authorization for an episode of care, which is the specific medical problem, condition, or illness being managed.¹⁶ The forms for prior authorization must be easily identifiable and accessible on the insurer's website and the website address must be included on insurance cards. The portal must provide instructions for submission, provide an electronic notification to a health care provider confirming receipt, and contain a comprehensive list of all procedures, services, drugs, devices, treatment, and durable medical equipment, and list when the health insurer requires prior authorization. The list must be updated at least quarterly.

PRIOR LEGISLATION

The 2025 Legislative Assembly passed Senate Bill No. 2280, which establishes requirements and procedures for prior authorization review organizations relating to the disclosure and review of prior authorization requests, decision deadlines, adverse determinations, appeal review, nonurgent circumstances, urgent health care services, and emergency medical conditions. The bill did not include a requirement that prior authorizations be submitted by electronic means. However, the bill requires prior authorization review organizations to report certain information to the Insurance Commissioner each year, including the number of prior authorization requests submitted by electronic means and the number of prior authorization requests submitted by nonelectronic means including mail and facsimile.

PRIOR STUDIES

Section 1 of Senate Bill No. 2389 (2023) provided for a study of prior authorization in health benefit plans. The committee received testimony from health care providers, insurers, and other interested stakeholders.

Testimony from health care providers indicated when properly used, prior authorization can control costs to ensure patients receive medically necessary care. Testimony indicated harmful impacts of prior authorization include delays in treatment, negative patient experiences, potential for treatment abandonment, barriers to innovative care models, and additional administrative burdens on providers.

Testimony received from insurers indicated prior authorization serves as an important safety check to confirm with the provider the care recommendation is safe, medically evidenced, and not duplicative. Testimony from insurers indicated there are several areas of opportunity to improve the prior authorization process, including ensuring providers submit requests only for services that require prior authorization, encouraging electronic submission of requests, and including all necessary supporting documentation with the initial request.

The committee made no recommendation to the Legislative Management regarding its study of the use of prior authorization in health benefit plans.

¹⁵ Tenn. Code Ann. § 56-7-3708 (2025).

¹⁶ W. Va. Code. § 33-25-8p (2025).

STUDY APPROACH

In conducting this study, the committee may wish to receive testimony from representatives of:

- The Insurance and Securities Department, regarding prior authorization requirements by electronic means;
- Health care providers, regarding technical methods for submitting prior authorizations;
- Insurance providers, regarding acceptable prior authorization submission methods and alternatives;
- The Information Technology Department, regarding technology capabilities; and
- The National Conference of State Legislatures and other interested parties, regarding what other states have done to address electronic prior authorizations.