House Engrossed

State of Arizona
House of Representatives
Fifty-fourth Legislature
Second Regular Session
2020

HOUSE BILL 2532

AN ACT

AMENDING SECTIONS 20-3401 AND 20-3403, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 26, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3406; RELATING TO PRIOR AUTHORIZATION FOR CERTAIN HEALTH CARE SERVICES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-3401, Arizona Revised Statutes, is amended to read:

20-3401. Definitions

In this article, unless the context otherwise requires:

1. "Adverse determination":

(a) Means a decision by a health care services plan or its utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary and plan coverage is therefore denied, reduced or terminated.

(b) Does not include a decision to deny, reduce or terminate services that are not covered for reasons other than medical necessity.

2. "Authorization":

(a) Means a determination by a health care services plan or its utilization review agent that a health care service has been reviewed and, based on the information provided, satisfies the health care services plan's requirements for medical necessity and appropriateness and that payment under the plan will be made for that health care service.

(b) Does not include any different or additional procedures, services or treatments beyond those specifically reviewed and approved by the health care services plan.

3. "Emergency ambulance services" has the same meaning prescribed in section 20-2801.

4. "Emergency services" has the same meaning prescribed in section 20-2801.

5. "Enrollee" means an individual or a dependent of that individual who is currently enrolled with and covered by a health care services plan. Enrollee includes an enrollee's legally authorized representative.

6. "Health care service":

(a) Means a health care procedure, treatment or service ~~for the diagnosis, management or treatment of acute pain, chronic pain or opioid use disorder~~ THAT IS COVERED UNDER THE HEALTH CARE SERVICES PLAN.

(b) Includes ~~the provision of~~ PROVIDING a prescription drug, device or durable medical equipment ~~for the treatment or management of acute pain, chronic pain or opioid use disorder~~ THAT IS COVERED UNDER THE HEALTH CARE SERVICES PLAN.

(c) Does not include treatments that are experimental, investigational or off label.

7. "Health care services plan":

(a) Means a plan offered by a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation or medical service corporation that contractually agrees to pay or make reimbursements for health care services expenses for one or more individuals residing in this state.

(b) Does not include benefits provided under limited benefit coverage as defined in section 20-1137.

8. "Medically necessary" or "medical necessity":

(a) Means covered health care services provided by a licensed provider acting within the provider's scope of practice in this state to prevent or treat disease, disability or other adverse conditions or their progression or to prolong life.

(b) Does not include services that are experimental or investigational or prescriptions that are prescribed off label.

9. "Medication-assisted treatment" has the same meaning prescribed in section 32-3201.01.

10. "PHARMACY BENEFIT MANAGER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-3321.

~~10.~~ 11. "Prior authorization requirement":

(a) Means a practice implemented by a health care services plan or its utilization review agent in which coverage of a health care service is dependent on an enrollee or a provider obtaining approval from the health care services plan before the service is performed, received or prescribed, as applicable.

(b) Includes preadmission review, pretreatment review, prospective review or utilization review procedures conducted by a health care services plan or its utilization review agent before providing a health care service.

(c) Does not include case management or step therapy protocols.

~~11.~~ 12. "Provider" means a physician, health care institution or other person or entity that is licensed or otherwise authorized to furnish health care services in this state.

~~12.~~ 13. "Urgent health care service" means a health care service with respect to which the application of the time periods for making a nonexpedited prior authorization decision, in the opinion of a provider with knowledge of the enrollee's medical condition, could either:

(a) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function.

(b) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

~~13.~~ 14. "Utilization review agent" has the same meaning prescribed in section 20-2501.

Sec. 2. Section 20-3403, Arizona Revised Statutes, is amended to read:

20-3403. Prior authorization requirements; disclosures; access

A. If a health care services plan contains a prior authorization requirement, all of the following apply:

1. The health care services plan or its utilization review agent shall make available to all providers on its website or provider portal a listing of all prior authorization requirements. The listing shall clearly identify the specific health care services, drugs or devices to which a prior authorization requirement exists, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

2. The health care services plan or its utilization review agent shall allow providers to access the UNIFORM prior authorization request ~~form~~ FORMS APPROVED BY THE DEPARTMENT PURSUANT TO SECTION 20-3406 through the applicable electronic software system.

3. Beginning January 1, 2020, the health care services plan or its utilization review agent shall accept prior authorization requests through a secure electronic transmission.

4. The health care services plan or its utilization review agent shall provide at least two forms of access to request a prior authorization including telephone, fax or electronic means and shall have emergency after-hours procedures.

B. Beginning January 1, 2020, the health care services plan or its utilization review agent shall accept and respond to prior authorization requests for prescription benefits through a secure electronic transmission.

C. Beginning January 1, 2020, the health care services plan or its utilization review agent may enter into a contractual arrangement with a provider under which the plan agrees to process and respond to prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the provider or because internet connectivity is limited or unavailable where the provider is located.

Sec. 3. Title 20, chapter 26, article 1, Arizona Revised Statutes, is amended by adding section 20-3406, to read:

20-3406. Uniform prior authorization request forms; definition

A. NOTWITHSTANDING ANY OTHER LAW, ON OR BEFORE JANUARY 1, 2021, THE DEPARTMENT SHALL APPROVE A UNIFORM PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUGS, DEVICES OR DURABLE MEDICAL EQUIPMENT AND A UNIFORM PRIOR AUTHORIZATION REQUEST FORM FOR ALL OTHER HEALTH CARE PROCEDURES, TREATMENTS AND SERVICES. ON OR BEFORE JANUARY 1, 2022, ALL PROVIDERS SHALL USE ONLY THE APPROVED UNIFORM PRIOR AUTHORIZATION REQUEST FORMS AND ALL HEALTH CARE SERVICES PLANS AND UTILIZATION REVIEW AGENTS SHALL ACCEPT AND PROCESS PRIOR AUTHORIZATION REQUESTS SUBMITTED USING THE APPROVED UNIFORM PRIOR AUTHORIZATION REQUEST FORMS. PRIOR AUTHORIZATION REQUESTS THAT ARE SUBMITTED ON OR AFTER JANUARY 1, 2022 ARE INVALID UNLESS THE REQUESTS ARE SUBMITTED ON THE APPROVED UNIFORM PRIOR AUTHORIZATION REQUEST FORMS. THE UNIFORM PRIOR AUTHORIZATION REQUEST FORMS SHALL BOTH:

1 1. NOT EXCEED TWO PRINTED PAGES. THIS TWO-PAGE LIMIT DOES NOT
2 APPLY TO OR INCLUDE A PROVIDER'S NOTES OR DOCUMENTATION THAT THE PROVIDER
3 SUBMITS IN SUPPORT OF A PRIOR AUTHORIZATION REQUEST.
4 2. MEET THE ELECTRONIC SUBMISSION AND ACCEPTANCE REQUIREMENTS
5 PRESCRIBED IN SECTION 20-3403.
6 B. IN APPROVING THE UNIFORM PRIOR AUTHORIZATION REQUEST FORMS, THE
7 DEPARTMENT SHALL BOTH:
8 1. CONSIDER THE FOLLOWING:
9 (a) ANY EXISTING PRIOR AUTHORIZATION REQUEST FORMS THAT THE CENTERS
10 FOR MEDICARE AND MEDICAID SERVICES OR THE UNITED STATES DEPARTMENT OF
11 HEALTH AND HUMAN SERVICES HAS DEVELOPED.
12 (b) ANY NATIONAL STANDARDS RELATING TO ELECTRONIC PRIOR
13 AUTHORIZATION.
14 (c) ANY OTHER FORM ADOPTED BY THE DIRECTOR OR ANOTHER STATE AGENCY.
15 2. SEEK INPUT FROM INTERESTED STAKEHOLDERS, INCLUDING PROVIDERS,
16 HEALTH CARE SERVICES PLANS, UTILIZATION REVIEW AGENTS, PHARMACISTS AND
17 PHARMACY BENEFIT MANAGERS.
18 C. THIS SECTION DOES NOT PROHIBIT A PAYOR OR ANY ENTITY ACTING FOR
19 A PAYOR UNDER CONTRACT WITH THE PAYOR FROM USING A PRIOR AUTHORIZATION
20 METHODOLOGY THAT USES AN INTERNET WEBPAGE, AN INTERNET WEBPAGE PORTAL OR A
21 SIMILAR ELECTRONIC, INTERNET AND WEB-BASED SYSTEM IF THE METHODOLOGY IS
22 CONSISTENT WITH THE UNIFORM PRIOR AUTHORIZATION REQUEST FORMS APPROVED BY
23 THE DIRECTOR PURSUANT TO THIS SECTION.
24 D. FOR THE PURPOSES OF THIS SECTION, "PROVIDER" INCLUDES A HEALTH
25 PROFESSIONAL AS DEFINED IN SECTION 32-3218 OR A HEALTH CARE INSTITUTION
26 THAT IS LICENSED UNDER TITLE 36.