ARIZONA HOUSE OF REPRESENTATIVES

Fifty-seventh Legislature
First Regular Session

House: COM DPA 10-0-0-0 | 3rd Read 58-0-2-0
Senate: FIN DPA/SE 5-2-0-0 | 3rd Read 29-0-1-0
Final Pass: 53-1-6-0 | **Chapter**: 165

HB 2175: ~~claims; prior authorization; conduct~~
NOW: prior authorization; claims
Sponsor: Representative Willoughby, LD 13
Signed by the Governor

Overview
Provides for the review of a denial of a claim or prior authorization that involves a medical necessity.

History
A health care services plan or its utilization review agent may impose a prior authorization requirement for health care services provided to an enrollee. A prior authorization requirement is 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. If the prior authorization request is denied, the health care services plan or its utilization review agent shall state the specific reason for the denial. On a denial of a prior authorization request, the enrollee and the provider may exercise the review and appeal rights granted under the health care appeals process (A.R.S. §§ 20-3402, 20-3404).

Any direct denial of prior authorization of a service requested by a health care provider based on medical necessity by a health care insurer must be made in writing by a medical director who holds an active unrestricted license to practice medicine in Arizona. The written denial must include an explanation of why the treatment was denied, and the medical director who made the denial must sign the written denial. The health care insurer must send a copy of the written denial to the health care provider who requested the treatment (A.R.S. § 20-2510).

Provisions
1. Requires a medical director, before a health care insurer may deny a claim that involves medical necessity, to individually review the denial. (Sec. 1)
2. Instructs a medical director, before a health care insurer may issue a direct denial of a prior authorization that involves medical necessity, to individually review the denial. (Sec. 2)
3. Stipulates the medical director, during each individual review of a claim or prior authorization denial, must exercise independent medical judgment and is prohibited from relying solely on recommendations derived from any other source. (Sec. 1, 2)
4. Contains a delayed effective date of July 1, 2026. (Sec. 3)

☐ Prop 105 (45 votes) ☐ Prop 108 (40 votes) ☐ Emergency (40 votes) ☒ Fiscal Note