

REFERENCE TITLE: prior authorizations; habilitative services

State of Arizona
House of Representatives
Fifty-seventh Legislature
Second Regular Session
2026

HB 2250

Introduced by
Representative Bliss

AN ACT

AMENDING SECTION 20-2501, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 15, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-2512, 20-2513 AND 20-2514; AMENDING SECTIONS 20-2531, 20-3403, 20-3404 AND 20-3405, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-2501, Arizona Revised Statutes, is amended to
3 read:

4 20-2501. Definitions; scope

5 A. In this chapter, unless the context otherwise requires:

6 1. "Adverse determination":

7 (a) Means a utilization review determination by the utilization
8 review agent that a requested service or claim for service or a denial,
9 reduction or termination of a service, in whole or in part, is not a
10 covered service, or is not medically necessary or appropriate, including
11 health care setting, level of care or effectiveness of a covered benefit,
12 or is experimental or investigational under the plan if that determination
13 results in a documented denial or nonpayment of the service or claim.

14 (b) Includes a rescission.

15 2. "Benefits based on the health status of the insured" means a
16 contract of insurance to pay a fixed benefit amount, without regard to the
17 specific services received, to a policyholder who meets certain
18 eligibility criteria based on health status including:

19 (a) A disability income insurance policy that pays a fixed daily,
20 weekly or monthly benefit amount to an insured who is deemed to have a
21 disability as defined by the policy terms.

22 (b) A hospital indemnity policy that pays a fixed daily benefit
23 during hospital confinement.

24 (c) A disability insurance policy that pays a fixed daily, weekly
25 or monthly benefit amount to an insured who is certified by a licensed
26 health care professional as chronically ill as defined by the policy
27 terms.

28 (d) A disability insurance policy that pays a fixed daily, weekly
29 or monthly benefit amount to an insured who suffers from a prolonged
30 physical illness, disability or cognitive disorder as defined by the
31 policy terms.

32 3. "Claim":

33 (a) Means a request for payment for a service already provided.

34 (b) Does not include:

35 (i) Claim adjustments for usual and customary charges for a service
36 or coordination of benefits between health care insurers.

37 (ii) A request for payment under a policy or contract that pays
38 benefits based on the health status of the insured and that does not
39 reimburse the cost of or provide covered services.

40 4. "Covered service" means a service that is included in a policy,
41 evidence of coverage or similar document that specifies which services,
42 insurance or other benefits are included or covered.

1 5. "Denial":

2 (a) Means a direct or indirect determination regarding all or part
3 of a request for any service.

4 (b) Includes a denial, reduction or termination of a service or a
5 rescission or a direct determination regarding a claim that may trigger a
6 request for review.

7 (c) Does not include:

8 (i) Enforcement of a health care insurer's deductibles, copayments
9 or coinsurance requirements or adjustments for usual and customary
10 charges, deductibles, copayments or coinsurance requirements for a service
11 or coordination of benefits between health care insurers.

12 (ii) The rejection of a request for payment under a policy or
13 contract that pays benefits based on the health status of the insured and
14 that does not reimburse the cost of or provide covered services.

15 6. "ENROLLEE" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-3401.

16 ~~6.~~ 7. "Final internal adverse determination" means an adverse
17 determination that is upheld, in whole or in part, at the completion of
18 the health care insurer's internal levels of review or an adverse
19 determination with respect to which the internal levels of review have
20 been waived or deemed exhausted.

21 ~~7.~~ 8. "Grandfathered individual plan" means coverage provided by
22 an individual health care insurer which was purchased before March 23,
23 2010 and which has not lost such status due to changes in benefits.

24 ~~8.~~ 9. "Health care insurer" means a disability insurer, group
25 disability insurer, blanket disability insurer, health care services
26 organization, hospital service corporation, prepaid dental plan
27 organization, medical service corporation, dental service corporation or
28 optometric service corporation or a hospital, medical, dental and
29 optometric service corporation.

30 ~~9.~~ 10. "Health care setting":

31 (a) Means an institution providing health care services.

32 ~~, including but not limited to,~~

33 (b) INCLUDES:

34 (i) Hospitals and other licensed inpatient centers. ~~;~~

35 (ii) Ambulatory surgical or treatment centers. ~~;~~

36 (iii) Skilled nursing centers. ~~;~~

37 (iv) Residential treatment centers. ~~;~~

38 (v) Diagnostic, laboratory and imaging centers. ~~and~~

39 (vi) Rehabilitation and other therapeutic health settings.

40 ~~10.~~ 11. "Indirect denial" means a failure to communicate
41 authorization or nonauthorization to the member by the utilization review
42 agent within the prescribed time frames pursuant to section 20-3404 after
43 the utilization review agent receives the request for a covered service.

1 ~~11.~~ 12. "Internal levels of review" means ANY OF THE FOLLOWING:
2 (a) An expedited medical review and expedited appeal pursuant to
3 section 20-2534.
4 (b) An initial internal appeal pursuant to section 20-2535.
5 (c) A voluntary internal appeal pursuant to section 20-2536, if
6 applicable.
7 ~~12.~~ 13. "Provider" means the physician or other licensed
8 practitioner identified to the utilization review agent as having primary
9 responsibility for providing care, treatment and services rendered to a
10 patient.
11 ~~13.~~ 14. "Rescission" means a retroactive cancellation of coverage
12 that is not related to a failure to timely pay required premiums.
13 ~~14.~~ 15. "Service" means a diagnostic or therapeutic medical or
14 health care service, benefit or treatment.
15 ~~15.~~ 16. "Utilization review" means a system for reviewing the
16 appropriate and efficient allocation of inpatient hospital resources,
17 inpatient medical services and outpatient surgery services that are being
18 given or are proposed to be given to a patient, and of any medical,
19 surgical and health care services or claims for services that may be
20 covered by a health care insurer depending on determinable contingencies,
21 including without limitation outpatient services, in-office consultations
22 with medical specialists, specialized diagnostic testing, mental health
23 services, emergency care and inpatient and outpatient hospital services.
24 Utilization review does not include elective requests for the
25 clarification of coverage.
26 ~~16.~~ 17. "Utilization review agent" means a person or entity that
27 performs utilization review. For purposes of article 2 of this chapter,
28 utilization review agent has the same meaning prescribed in section
29 20-2530. For purposes of this chapter, utilization review agent does not
30 include:
31 (a) A governmental agency.
32 (b) An agent that acts on behalf of the governmental agency.
33 (c) An employee of a utilization review agent.
34 ~~17.~~ 18. "Utilization review plan" means a summary description of
35 the utilization review guidelines, protocols, procedures and written
36 standards and criteria of a utilization review agent.
37 B. For the purposes of this chapter, utilization review by an
38 optometric service corporation applies only to nonsurgical medical and
39 health care services.
40 Sec. 2. Title 20, chapter 15, article 1, Arizona Revised Statutes,
41 is amended by adding sections 20-2512, 20-2513 and 20-2514, to read:
42 20-2512. Continuity of care for enrollees
43 A. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT SHALL HONOR A
44 PRIOR AUTHORIZATION THAT WAS GRANTED TO AN ENROLLEE BY A PREVIOUS HEALTH
45 CARE INSURER OR UTILIZATION REVIEW AGENT FOR AT LEAST NINETY DAYS AFTER

1 THE ENROLLEE'S COVERAGE UNDER A NEW HEALTH CARE PLAN COMMENCES IF BOTH OF
2 THE FOLLOWING APPLY:

3 1. THE HEALTH CARE SERVICE IS A COVERED BENEFIT UNDER THE NEW
4 HEALTH CARE PLAN.

5 2. THE ENROLLEE, THE ENROLLEE'S PROVIDER OR THE PREVIOUS HEALTH
6 CARE INSURER PROVIDES DOCUMENTATION TO THE HEALTH CARE INSURER OR
7 UTILIZATION REVIEW AGENT REGARDING THE GRANTED PRIOR AUTHORIZATION.

8 B. DURING THE TIME PERIOD PRESCRIBED IN SUBSECTION A OF THIS
9 SECTION, A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY PERFORM ITS
10 OWN REVIEW TO GRANT A NEW AUTHORIZATION.

11 C. IF THERE IS A CHANGE IN COVERAGE OR APPROVAL CRITERIA FOR A
12 PREVIOUSLY AUTHORIZED HEALTH CARE SERVICE UNDER AN ENROLLEE'S CURRENT
13 HEALTH CARE PLAN, THE CHANGE IN COVERAGE OR APPROVAL CRITERIA MAY NOT
14 AFFECT THE ENROLLEE IF THE ENROLLEE RECEIVED A PRIOR AUTHORIZATION WITHIN
15 ONE YEAR BEFORE THE EFFECTIVE DATE OF THE CHANGE IN COVERAGE OR APPROVAL
16 CRITERIA. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY REQUIRE A
17 NEW PRIOR AUTHORIZATION REQUEST ONE YEAR AFTER THE ENROLLEE'S PREVIOUS
18 PRIOR AUTHORIZATION REQUEST.

19 D. AN ENROLLEE MAY NOT BE REQUIRED TO REPEAT A STEP THERAPY
20 PROTOCOL IF THE ENROLLEE, WHILE UNDER THE ENROLLEE'S CURRENT OR PREVIOUS
21 HEALTH CARE PLAN, USED A PRESCRIPTION DRUG THAT WAS REQUIRED BY THE STEP
22 THERAPY PROTOCOL OR ANOTHER PRESCRIPTION DRUG IN THE SAME PHARMACOLOGICAL
23 CLASS WITH A SIMILAR EFFICACY OR SIDE EFFECT PROFILE OR THE SAME MECHANISM
24 OF ACTION AND THE ENROLLEE DISCONTINUED USING THE PRESCRIPTION DRUG DUE TO
25 LACK OF EFFICACY OR EFFECTIVENESS OR AN ADVERSE EVENT OR BECAUSE THE
26 PRESCRIPTION DRUG WAS CONTRAINDICATED. THE ENROLLEE'S PRESCRIBING
27 PROVIDER SHALL SUBMIT ANY JUSTIFICATION AND CLINICAL INFORMATION, ON
28 REQUEST, THAT DEMONSTRATES A CLINICALLY VALID REASON FOR WHY THE COVERED
29 PRESCRIBED DRUG IS NEEDED AND DOCUMENTATION OF COMPLETION OF ANY PREVIOUS
30 STEP THERAPY PROTOCOLS FOR THE PRESCRIBED DRUG.

31 20-2513. Prior authorization for rehabilitative or
32 habilitative services

33 A. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY NOT
34 REQUIRE A PRIOR AUTHORIZATION FOR REHABILITATIVE OR HABILITATIVE SERVICES
35 THAT INCLUDE PHYSICAL THERAPY SERVICES OR OCCUPATIONAL THERAPY SERVICES
36 FOR THE FIRST TWELVE VISITS FOR EACH NEW EPISODE OF CARE. FOR THE
37 PURPOSES OF THIS SUBSECTION, "NEW EPISODE OF CARE" MEANS EITHER OF THE
38 FOLLOWING:

39 1. TREATMENT FOR A NEW CONDITION.

40 2. TREATMENT FOR A RECURRING CONDITION THAT THE ENROLLEE HAS NOT
41 BEEN TREATED FOR WITHIN THE PREVIOUS NINETY DAYS.

42 B. THIS SECTION DOES NOT LIMIT THE RIGHT OF A HEALTH CARE INSURER
43 OR UTILIZATION REVIEW AGENT TO DENY A CLAIM IF AN APPROPRIATE PROSPECTIVE
44 OR RETROSPECTIVE UTILIZATION REVIEW CONCLUDES THAT THE HEALTH CARE SERVICE
45 WAS NOT MEDICALLY NECESSARY.

20-2514. Provider exemptions from prior authorization requirements

A. A PROVIDER IS EXEMPT FROM COMPLETING A PRIOR AUTHORIZATION REQUEST FOR A HEALTH CARE SERVICE, EXCLUDING THE PRACTICE OF PHARMACY AND PRESCRIPTION DRUGS, FOR TWELVE MONTHS IF:

1. IN THE MOST RECENT TWELVE-MONTH PERIOD, THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT AUTHORIZED AT LEAST NINETY PERCENT OF PRIOR AUTHORIZATION REQUESTS, ROUNDED DOWN TO THE NEAREST WHOLE NUMBER, THAT THE PROVIDER SUBMITTED FOR THAT HEALTH CARE SERVICE.

2. THE PROVIDER HAS MADE A PRIOR AUTHORIZATION REQUEST FOR THAT HEALTH CARE SERVICE AT LEAST FIVE TIMES IN THE MOST RECENT TWELVE-MONTH PERIOD.

B. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY EVALUATE WHETHER A PROVIDER CONTINUES TO QUALIFY FOR AN EXEMPTION PRESCRIBED IN SUBSECTION A OF THIS SECTION. THIS SUBSECTION DOES NOT REQUIRE A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT TO EVALUATE AN EXISTING EXEMPTION OR PREVENT A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT FROM ESTABLISHING A LONGER EXEMPTION PERIOD.

C. A PROVIDER IS NOT REQUIRED TO REQUEST AN EXEMPTION IN ORDER TO BE EXEMPT UNDER SUBSECTION A OF THIS SECTION.

D. A PROVIDER WHO DOES NOT RECEIVE AN EXEMPTION UNDER SUBSECTION A OF THIS SECTION MAY REQUEST FROM THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT EVIDENCE AS TO WHY THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT DENIED THE PROVIDER'S REQUEST FOR THE EXEMPTION. THE PROVIDER MAY MAKE THIS REQUEST ONE TIME PER CALENDAR YEAR PER HEALTH CARE SERVICE REQUESTED. A PROVIDER MAY APPEAL A HEALTH CARE INSURER'S OR UTILIZATION REVIEW AGENT'S DECISION TO DENY AN EXEMPTION.

E. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY REVOKE A PROVIDER'S EXEMPTION ONLY AT THE END OF THE TWELVE-MONTH EXEMPTION PERIOD IF THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT:

1. MAKES A DETERMINATION THAT THE PROVIDER WOULD NOT HAVE MET THE NINETY PERCENT, ROUNDED DOWN TO THE NEAREST WHOLE NUMBER, AUTHORIZATION BASED CRITERIA ON A RETROSPECTIVE REVIEW OF THE CLAIMS FOR A PARTICULAR HEALTH CARE SERVICE FOR WHICH THE EXEMPTION APPLIED.

2. PROVIDES THE PROVIDER WITH INFORMATION THAT THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT RELIED ON IN MAKING A DETERMINATION TO REVOKE THE EXEMPTION.

3. PROVIDES THE PROVIDER WITH A PLAIN LANGUAGE EXPLANATION THAT INCLUDES INSTRUCTIONS ON HOW TO APPEAL THE DETERMINATION TO REVOKE THE EXEMPTION.

F. AN EXEMPTION UNDER SUBSECTION A OF THIS SECTION REMAINS IN EFFECT UNTIL EITHER:

1. THE THIRTIETH CALENDAR DAY AFTER THE DATE THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT NOTIFIES THE PROVIDER OF THE HEALTH CARE INSURER'S OR UTILIZATION REVIEW AGENT'S DETERMINATION TO REVOKE THE EXEMPTION.

2. THE FIFTH CALENDAR DAY AFTER THE EXEMPTION REVOCATION IS UPHELD ON APPEAL, IF THE PROVIDER APPEALS THE DETERMINATION.

G. A DETERMINATION TO REVOKE OR DENY AN EXEMPTION SHALL BE MADE BY A LICENSED HEALTH CARE PROVIDER WHO IS OF THE SAME OR SIMILAR SPECIALTY AS THE PROVIDER BEING CONSIDERED FOR AN EXEMPTION AND WHO HAS EXPERIENCE IN PROVIDING THE HEALTH CARE SERVICE FOR WHICH THE POTENTIAL EXEMPTION APPLIES.

H. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT SHALL GIVE NOTICE TO A PROVIDER WHO RECEIVES AN EXEMPTION THAT INCLUDES ALL OF THE FOLLOWING:

1. A STATEMENT THAT THE PROVIDER QUALIFIES FOR AN EXEMPTION FOR PRIOR AUTHORIZATION REQUIREMENTS.

2. A LIST OF HEALTH CARE SERVICES FOR WHICH THE EXEMPTION APPLIES.

3. A STATEMENT THAT THE DURATION OF THE EXEMPTION IS TWELVE MONTHS.

I. A HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT MAY NOT DENY OR REDUCE PAYMENT FOR A HEALTH CARE SERVICE THAT IS EXEMPTED FROM A PRIOR AUTHORIZATION REQUIREMENT UNDER THIS SECTION AND THAT INCLUDES A HEALTH CARE SERVICE THAT IS PERFORMED OR SUPERVISED BY ANOTHER PROVIDER IF THE PROVIDER WHO ORDERED THE HEALTH CARE SERVICE RECEIVED A PRIOR AUTHORIZATION EXEMPTION, UNLESS THE RENDERING PROVIDER:

1. KNOWINGLY AND MATERIALLY MISREPRESENTS THE HEALTH CARE SERVICE IN A REQUEST FOR PAYMENT THAT IS SUBMITTED TO THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT WITH THE SPECIFIC INTENT TO DECEIVE AND OBTAIN AN UNLAWFUL PAYMENT FROM THE HEALTH CARE INSURER OR UTILIZATION REVIEW AGENT.

2. FAILS TO SUBSTANTIALLY PERFORM THE HEALTH CARE SERVICE.

Sec. 3. Section 20-2531, Arizona Revised Statutes, is amended to read:

~~20-2531.~~ Applicability; requirements; exception

A. Notwithstanding article 1 of this chapter and subject to subsection ~~B~~ C of this section, this article applies to all utilization review decisions made by utilization review agents and health care insurers operating in this state.

B. IF AN ENROLLEE'S PROVIDER INITIATES AN APPEAL, THE ENROLLEE'S PROVIDER MAY REQUEST THAT A PROVIDER WHO HAS SPECIALIZED KNOWLEDGE IN A PRACTICE AREA REVIEW THE APPEAL.

~~B~~ C. Each utilization review agent and each health care insurer operating in this state whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials that do all of the following:

1. Meet the requirements of this article.

2. Are consistent with chapter 1 of this title.

3. Comply with section 20-2505, paragraphs 2 through 6.

1 4. COMPLY WITH SECTION 20-3403, SUBSECTION A, PARAGRAPH 4.
2 5. ENSURE THAT A PROVIDER WHO REVIEWS AN APPEAL MEETS ALL OF THE
3 FOLLOWING:
4 (a) COMPLIES WITH PARAGRAPH 6 OF THIS SUBSECTION.
5 (b) DOES NOT HAVE A FINANCIAL INTEREST IN THE DETERMINATION.
6 (c) IS NOT DIRECTLY INVOLVED IN THE INITIAL ADVERSE DETERMINATION.
7 (d) CONSIDERS ALL KNOWN CLINICAL ASPECTS OF THE HEALTH CARE SERVICE
8 UNDER REVIEW, INCLUDING A REVIEW OF ALL OF THE FOLLOWING:
9 (i) PERTINENT MEDICAL RECORDS THAT ARE PROVIDED TO THE HEALTH CARE
10 INSURER OR UTILIZATION REVIEW AGENT.
11 (ii) RELEVANT RECORDS THAT ARE PROVIDED TO THE HEALTH CARE INSURER
12 OR UTILIZATION REVIEW AGENT BY A HEALTH CARE FACILITY.
13 (iii) PERTINENT RECORDS OR MATERIALS THAT ARE PROVIDED BY THE
14 ENROLLEE.
15 (iv) PERTINENT INFORMATION THAT IS PROVIDED BY THE ENROLLEE'S
16 PROVIDER AND ANY MEDICAL LITERATURE.
17 6. REQUIRE A PROVIDER WHO REVIEWS AN APPEAL TO:
18 (a) HAVE A CURRENT AND UNRESTRICTED LICENSE TO PRACTICE WITHIN THE
19 SCOPE OF THE PROVIDER'S MEDICAL PROFESSION IN THIS STATE OR ANY OTHER
20 TERRITORY OR STATE.
21 (b) HAVE KNOWLEDGE OF THE COVERAGE CRITERIA.
22 (c) HAVE SUFFICIENT MEDICAL KNOWLEDGE IN AN APPLICABLE PRACTICE
23 AREA OR SPECIALTY.
24 (d) NOT HAVE BEEN EMPLOYED BY A HEALTH CARE PLAN OR UTILIZATION
25 REVIEW AGENT OR BEEN UNDER CONTRACT WITH THE HEALTH CARE PLAN OR
26 UTILIZATION REVIEW AGENT OTHER THAN TO PARTICIPATE IN ONE OR MORE OF THE
27 HEALTH CARE INSURER'S OR UTILIZATION REVIEW AGENT'S HEALTH CARE PROVIDER
28 NETWORKS, TO PERFORM REVIEWS OF APPEALS OR TO OTHERWISE HAVE ANY FINANCIAL
29 INTEREST IN THE OUTCOME OF THE APPEAL.
30 ~~C.~~ D. This article does not apply to utilization review:
31 1. Performed under contract with the federal government for
32 utilization review of patients eligible for all services under title XVIII
33 of the social security act.
34 2. Performed by a self-insured or self-funded employee benefit plan
35 or a multiemployer employee benefit plan created in accordance with and
36 pursuant to 29 United States Code section 186(c) if the regulation of that
37 plan is preempted by section 514(b) of the employee retirement income
38 security act of 1974 (29 United States Code section 1144(b)), but this
39 article does apply to a health care insurer that provides coverage for
40 services as part of an employee benefit plan.
41 3. Of work related injuries and illnesses covered under the
42 workers' compensation laws in title 23.

4. Performed under the terms of a policy that pays benefits based on the health status of the insured and does not reimburse the cost of or provide covered services.

5. Performed under the terms of a long-term care insurance policy as defined in section 20-1691.

6. Performed under the terms of a medicare supplement policy as defined by the department.

~~D.~~ E. This article does not create any new private right or cause of action for or on behalf of any member. This article provides only an administrative process for a member to pursue an external independent review of a denial for a covered service or claim for a covered service.

~~F.~~ F. Utilization review activities involving retrospective claims review are limited to the provisions of this article only as clearly and specifically provided in the provisions of this article.

~~F.~~ G. The processes available under this article do not apply to a denial of a nonformulary exception request that was appealed pursuant to 45 Code of Federal Regulations section 156.122(c). A provider or enrollee may appeal a denial of a nonformulary exception for a plan covered by 45 Code of Federal Regulations section 156.122(c) through the process prescribed in the federal rule.

Sec. 4. Section 20-3403, Arizona Revised Statutes, is amended to read:

20-3403. Prior authorization requirements; disclosures; access; rules

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 AND ENROLLEES AND THE PUBLIC on its PUBLICLY ACCESSIBLE website ~~or provider portal~~ a listing of all prior authorization requirements AND RESTRICTIONS AND SHALL DESCRIBE THESE REQUIREMENTS AND RESTRICTIONS IN DETAIL AND IN EASILY UNDERSTANDABLE LANGUAGE. 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. EACH HEALTH CARE SERVICES PLAN OR ITS UTILIZATION REVIEW AGENT MAY NOT IMPLEMENT A NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION UNLESS THE HEALTH CARE SERVICES PLAN'S OR ITS UTILIZATION REVIEW AGENT'S WEBSITE IS UPDATED TO REFLECT THE NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION. A HEALTH CARE SERVICES PLAN OR ITS UTILIZATION REVIEW AGENT SHALL PROVIDE A COPY OF THE RESTRICTIONS OR REQUIREMENTS TO A PROVIDER WITHIN TWENTY-FOUR HOURS ON REQUEST OF THE PROVIDER.

3. EACH HEALTH CARE SERVICES PLAN OR ITS UTILIZATION REVIEW AGENT SHALL PROVIDE AFFECTED CONTRACTED PROVIDERS AND ENROLLEES WITH WRITTEN NOTICE OF ANY NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION AT LEAST SIXTY DAYS BEFORE THE NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION IS IMPLEMENTED.

4. EACH HEALTH CARE SERVICES PLAN OR ITS UTILIZATION REVIEW AGENT SHALL ENSURE THAT ALL ADVERSE DETERMINATIONS ARE MADE BY A LICENSED PHYSICIAN OR OTHER APPROPRIATE PROVIDER WHO HAS:

(a) SUFFICIENT MEDICAL KNOWLEDGE IN AN APPLICABLE PRACTICE AREA OR SPECIALTY AND WHO CURRENTLY HOLDS AN UNRESTRICTED LICENSE, REGISTRATION OR CERTIFICATE TO PRACTICE IN THIS STATE OR ANY OTHER STATE.

(b) KNOWLEDGE OF THE COVERAGE CRITERIA.

(c) KNOWLEDGE OF THE ENROLLEE'S MEDICAL HISTORY AND DIAGNOSIS.

~~2.~~ 5. The health care services plan or its utilization review agent shall allow providers to access the uniform prior authorization request forms approved by the department pursuant to section 20-3406 through the applicable electronic software system.

~~3.~~ 6. The health care services plan or its utilization review agent shall accept prior authorization requests through a secure electronic transmission.

~~4.~~ 7. 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. 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. 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.

D. THE DEPARTMENT MAY ADOPT RULES THAT REQUIRE HEALTH CARE INSURERS OR UTILIZATION REVIEW AGENTS TO DISCLOSE INFORMATION REGARDING PRIOR AUTHORIZATION REQUESTS AND ADVERSE DETERMINATIONS TO THE DEPARTMENT AND TO THE PUBLIC IN STATISTICAL FORM. AT A MINIMUM, THE STATISTICS SHALL INCLUDE ALL OF THE FOLLOWING CATEGORIES:

1. THE PROVIDER'S SPECIALTY.

2. ANY MEDICATION OR DIAGNOSTIC TEST OR PROCEDURE.

3. THE INDICATION OFFERED.

4. THE REASON FOR THE ADVERSE DETERMINATION.

5. WHETHER THE ADVERSE DETERMINATION WAS APPEALED.

1 6. WHETHER THE ADVERSE DETERMINATION WAS UPHELD OR REVERSED ON
2 APPEAL.

3 7. THE TIME BETWEEN THE SUBMISSION OF THE PRIOR AUTHORIZATION
4 REQUEST AND THE REQUEST AUTHORIZATION OR THE INITIAL ADVERSE
5 DETERMINATION.

6 Sec. 5. Section 20-3404, Arizona Revised Statutes, is amended to
7 read:

8 20-3404. Prior authorization requirement timelines

9 A. If ~~a plan offered by~~ a health care services plan contains a
10 prior authorization requirement, all of the following apply:

11 1. For prior authorization requests concerning urgent health care
12 services, the health care services plan or its utilization review agent
13 shall:

14 (a) Notify the provider of the prior authorization or adverse
15 determination not later than ~~five~~ THREE CALENDAR days after the receipt
16 of all necessary information to support the prior authorization request.

17 (b) PROVIDE AN OPPORTUNITY FOR THE PROVIDER TO DISCUSS THE MEDICAL
18 NECESSITY OF THE HEALTH CARE SERVICE WITH AN INDIVIDUAL WHO HAS
19 DECISION-MAKING AUTHORITY AND WHO IS RESPONSIBLE FOR AUTHORIZING THE
20 HEALTH CARE SERVICE.

21 2. For prior authorization requests concerning health care services
22 that are not urgent health care services, the health care services plan or
23 its utilization review agent shall:

24 (a) Notify the provider of the prior authorization or adverse
25 determination not later than ~~fourteen~~ FIVE CALENDAR days after receipt of
26 all necessary information to support the prior authorization request.

27 (b) PROVIDE AN OPPORTUNITY FOR THE PROVIDER TO DISCUSS THE MEDICAL
28 NECESSITY OF THE HEALTH CARE SERVICE WITH AN INDIVIDUAL WHO HAS
29 DECISION-MAKING AUTHORITY AND WHO IS RESPONSIBLE FOR AUTHORIZING THE
30 HEALTH CARE SERVICE.

31 3. On receipt of information from the provider in support of a
32 prior authorization request, the health care services plan or its
33 utilization review agent shall provide a receipt in the same format that
34 the request was made to the provider acknowledging that the information
35 was received, unless the necessary return contact information is not
36 provided.

37 B. The notification required under subsection A of this section
38 shall state whether the prior authorization request is approved, denied or
39 incomplete. If the prior authorization request is denied, the health care
40 services plan or its utilization review agent shall state the specific
41 reason for the denial. For a request that is considered incomplete, the
42 provider shall have the opportunity to submit additional information.
43 Once the provider submits additional information on incomplete requests,
44 the health care services plan has five days to review and respond to

1 requests for health care services deemed urgent and fourteen days to
2 review and respond to requests for health care services deemed not urgent.

3 C. A prior authorization request is deemed granted if a health care
4 services plan or its utilization review agent fails to comply with the
5 deadlines and notification requirements of this section.

6 D. A prior authorization request, once granted or deemed granted,
7 is binding on the health care services plan, may be relied on by the
8 enrollee and provider and may not be rescinded or modified by a health
9 care services plan or its utilization review agent after the provider
10 renders the authorized health care services in good faith and pursuant to
11 the authorization unless there is evidence of fraud or misrepresentation
12 by the provider.

13 E. On a denial of a prior authorization request, the enrollee and
14 the provider may exercise the review and appeal rights specified in
15 chapter 15, article 2 of this title.

16 Sec. 6. Section 20-3405, Arizona Revised Statutes, is amended to
17 read:

18 20-3405. Prior authorization of prescription drugs for
19 chronic pain conditions

20 A. For a prior authorization request related to a chronic pain
21 condition, the health care services plan or its utilization review agent
22 shall honor a prior authorization that is granted for an approved
23 prescription drug for the earliest of the following:

- 24 1. Six months after the date of the prior authorization approval.
- 25 2. The last day of the enrollee's coverage under the plan.

26 B. In relation to a prior authorization described in subsection A
27 of this section, the health care services plan or its utilization review
28 agent may request that the provider submit information to the health care
29 services plan or its utilization review agent indicating that the
30 enrollee's chronic pain condition has not changed and that the
31 continuation of the treatment is not negatively impacting the enrollee's
32 health. If the provider does not respond within five business days after
33 the date on which the request was received, the health care services plan
34 or its utilization review agent may terminate the prior authorization.

35 C. This section does not apply to:

36 1. Prescription medications if the United States food and drug
37 administration recommends that the drug be used only for periods of less
38 than six months.

39 2. Any opioid or benzodiazepine or other schedule I or II
40 controlled substance.

41 3. ANY MEDICATION THAT IS PRESCRIBED FOR OPIOID USE DISORDER.

1 D. This section does not prohibit the substitution of any drug that
2 has received a six-month prior authorization under subsection A of this
3 section when there is a release of a United States food and drug
4 administration-approved comparable brand product or a generic counterpart
5 of a brand product that is listed as therapeutically equivalent in the
6 United States food and drug administration's publication titled approved
7 drug products with therapeutic equivalence evaluations.

8 E. This section does not prohibit a health care services plan from
9 granting a prior authorization for a duration longer than six months.