By Senator Simon

3-01928A-23 20231434__

A bill to be entitled

An act relating to prior authorization; amending s. 627.42392, F.S.; defining terms; redefining the term "health insurer" as "utilization review entity" and revising the definition; requiring utilization review entities to establish and offer a prior authorization process for accepting electronic prior authorization requests; specifying a requirement for the process; specifying additional requirements and procedures for, and restrictions and limitations on, utilization review entities relating to prior authorization for covered health care benefits; defining the term "medications for opioid use disorder"; providing construction; making technical changes; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term:

(a) "Adverse determination" means a decision by a utilization review entity that the health care services furnished or proposed to be furnished to an insured are not medically necessary or are experimental or investigational, and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate services that are not covered for reasons other than their medical necessity or

experimental or investigational nature is not an adverse determination for purposes of this section.

(b) "Electronic prior authorization process" does not include transmissions through a facsimile machine.

(c) "Emergency health care services" has the same meaning as "emergency services and care" as defined in s. 395.002(9).

(d) "Prior authorization" means the process by which a utilization review entity determines the medical necessity or appropriateness, or both, of otherwise covered health care services before the rendering of such health care services. The term also includes any utilization review entity's requirement that an insured or health care provider notify the utilization review entity before providing a health care service.

(e) "Urgent health care service" means a health care service that, if the timeframe for making a nonexpedited prior authorization is applied, in the opinion of a physician with knowledge of the patient's medical condition, could:

1. Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

2. Subject the patient to severe pain that cannot be adequately managed without the care, treatment, or prescription drug that is the subject of the prior authorization request.

(f) "Utilization review entity" ~~"health insurer"~~ means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962(10), ~~or~~ a health maintenance organization as defined in s. 641.19(12), a pharmacy benefit manager as defined in s. 624.490, or any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or

other health benefits under a policy, plan, or contract to a person treated by a health care professional in this state.

(2) Beginning January 1, 2024, a utilization review entity must establish and offer a secure, interactive online electronic prior authorization process for accepting electronic prior authorization requests. The process must allow a person seeking prior authorization the ability to upload documentation if such documentation is required by the utilization review entity to adjudicate the prior authorization request.

(3) Notwithstanding any other ~~provision of~~ law, effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a utilization review entity that ~~health insurer, or a pharmacy benefits manager on behalf of the health insurer, which~~ does not provide an electronic prior authorization process for use by its contracted providers~~,~~ shall use only ~~use~~ the prior authorization form ~~that has been~~ approved by the ~~Financial Services~~ commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the utilization review entity ~~health insurer~~ to make a decision. At a minimum, the form must include:

(a) ~~(1)~~ Sufficient patient information to identify the member, date of birth, full name, and health plan ID number;

(b) ~~(2)~~ The provider's ~~provider~~ name, address, and phone number;

(c) ~~(3)~~ The medical procedure, course of treatment, or

prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed;

(d) ~~(4)~~ Any laboratory documentation required; and

(e) ~~(5)~~ An attestation that all information provided is true and accurate.

(4) ~~(3)~~ The ~~Financial Services~~ commission, in consultation with the Agency for Health Care Administration, shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(5) ~~(4)~~ Electronic prior authorization approvals do not preclude benefit verification or medical review by the utilization review entity ~~insurer~~ under either the medical or pharmacy benefits.

(6) A utilization review entity's prior authorization process may not require information that is not needed to make a determination or facilitate a determination of medical necessity of the requested medical procedure, course of treatment, or prescription drug benefit.

(7) A utilization review entity shall disclose all of its prior authorization requirements and restrictions, including any written clinical criteria, in a publicly accessible manner on its website. Such information must be explained in detail and in clear and ordinary terms.

(8) A utilization review entity may not implement any new requirement or restriction or make changes to existing requirements or restrictions on obtaining prior authorization unless:

(a) The changes have been available on a publicly accessible website for at least 60 days before they are

implemented; and

(b) Insureds and health care providers affected by the new requirements and restrictions or by the changes to the requirements and restrictions are provided with a written notice of the changes at least 60 days before they are implemented. Such notice must be delivered electronically or by other means as agreed to by the insured or the health care provider.

(9) A utilization review entity shall make available data regarding prior authorization approvals and denials on its website in a readily accessible format, which must include categories specifying:

(a) Physician specialty;

(b) Medication or diagnostic test or procedure;

(c) The indication offered;

(d) The reason for denial, if applicable;

(e) If denied, whether the denial was appealed;

(f) If a denial was appealed, whether it was approved or denied on appeal; and

(g) The time between submission and the response.

This subsection does not apply to the expansion of health care services coverage.

(10) A utilization review entity shall ensure that all adverse determinations are made by a physician licensed pursuant to chapter 458 or chapter 459. The physician must:

(a) Possess a current and valid nonrestricted license to practice medicine in this state;

(b) Be of the same specialty as the physician who typically manages the medical condition or disease or who provides the

health care service involved in the request; and

(c) Have experience treating patients with the medical condition or disease for which the health care service is being requested.

(11) Notice of an adverse determination must be provided by e-mail to the health care provider that initiated the prior authorization. The notice must include:

(a) The name, title, e-mail address, and telephone number of the physician responsible for making the adverse determination;

(b) The written clinical criteria, if any, and any internal rule, guideline, or protocol the utilization review entity relied upon in making the adverse determination, and how those provisions apply to the insured's specific medical circumstance;

(c) Information for the insured and the insured's health care provider which describes the procedure through which the insured or health care provider may request a copy of any report developed by personnel performing the review that led to the adverse determination; and

(d) An explanation to the insured and the insured's health care provider on how to appeal the adverse determination.

(12) If a utilization review entity requires prior authorization of a nonurgent health care service, the utilization review entity must make an authorization or adverse determination and notify the insured and the insured's provider of such service of the decision within 2 business days after obtaining all necessary information to make the authorization or adverse determination. For purposes of this subsection, necessary information includes the results of any face-to-face

clinical evaluation or second opinion that may be required.

(13) A utilization review entity shall render an expedited authorization or adverse determination concerning an urgent health care service and notify the insured and the insured's provider of such service of the expedited prior authorization or adverse determination no later than 1 business day after receiving all information needed to complete the review of the requested urgent health care service.

(14) A utilization review entity may not require prior authorization for prehospital transportation or for provision of an emergency health care service.

(15) A utilization review entity may not require prior authorization for the provision of medications for opioid use disorder. As used in this subsection, the term "medications for opioid use disorder" means the use of medications approved by the United States Food and Drug Administration (FDA), commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. Such FDA-approved medications used to treat opioid addiction include, but are not limited to, methadone; buprenorphine, alone or in combination with naloxone; and extended-release injectable naltrexone. Such types of behavioral therapies include, but are not limited to, individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities.

(16) A utilization review entity may not revoke, limit, condition, or restrict a prior authorization if care is provided within 45 business days after the date the health care provider received the prior authorization. A utilization review entity

shall pay the health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization unless:

(a) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity;

(b) The health care service was no longer a covered benefit on the day it was provided, and the utilization review entity notified the health care provider in writing of this fact before the health care service was provided;

(c) The health care provider was no longer contracted with the insured's health insurance plan on the date the care was provided, and the utilization review entity notified the health care provider in writing of this fact before the health care service was provided;

(d) The health care provider failed to meet the utilization review entity's timely filing requirements;

(e) The authorized service was never performed; or

(f) The insured was no longer eligible for health care coverage on the day the care was provided and the utilization review entity notified the health care provider in writing of this fact before the health care service was provided.

(17) If a utilization review entity required a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the length of the treatment and the utilization review entity may not require the insured to obtain a prior authorization again for the health care service.

(18) A utilization review entity may not impose an additional prior authorization requirement with respect to a surgical or otherwise invasive procedure, or any item furnished as part of the surgical or invasive procedure, if the procedure or item is furnished during the perioperative period of another procedure for which prior authorization was granted by the utilization review entity.

(19) If there is a change in coverage or approval criteria for a previously authorized health care service, the change in coverage or approval criteria may not affect an insured who received prior authorization before the effective date of the change for the remainder of the insured's plan year.

(20) A utilization review entity shall continue to honor a prior authorization it has granted to an insured when the insured changes products under the same carrier.

(21) Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this section shall result in any health care services subject to review to be automatically deemed authorized by the utilization review entity.

(22) The provisions of this section cannot be waived by contract. Any contractual arrangement or action taken in conflict with this section or that purports to waive any requirement of this section is void.

Section 2. This act shall take effect July 1, 2023.