1 A bill to be entitled
2 An act relating to prior authorization for health care
3 services; amending s. 627.42392, F.S.; providing
4 definitions; deleting the definition of the term
5 "health insurer"; providing a process to accept
6 electronic requests for prior authorization for health
7 care services; providing requirements for the
8 electronic prior authorization process; providing
9 notification requirements for prior authorization
10 determinations; prohibiting requirements for prior
11 authorizations for certain health care services and
12 medications; prohibiting prior authorization
13 revocations, limitations, conditions, and restrictions
14 under a specified circumstance; providing requirements
15 for payments to health care providers; providing
16 length of prior authorization validity under certain
17 circumstances; prohibiting requirements for additional
18 prior authorizations under certain circumstances;
19 providing construction; prohibiting certain provisions
20 from being waived; providing an effective date.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Section 627.42392, Florida Statutes, is amended
25 to read:

26 627.42392 Prior authorization.—
27 (1) As used in this section, the term:
28 (a) "Adverse determination" means a decision by a
29 utilization review entity that the health care services provided
30 or proposed to be provided to an insured are not medically
31 necessary or are experimental or investigational and that
32 benefit coverage is therefore denied, reduced, or terminated.
33 For purposes of this section, the term does not include a
34 decision to deny, reduce, or terminate services that are not
35 covered for reasons other than their medical necessity or
36 experimental or investigational nature.
37 (b) "Electronic prior authorization process" does not
38 include a transmission through a facsimile machine.
39 (c) "Emergency health care service" has the same meaning
40 as the term "emergency services and care" as defined in s.
41 395.002(9).
42 (d) "Prior authorization" means the process by which a
43 utilization review entity determines the medical necessity or
44 appropriateness of otherwise covered health care services before
45 the provision of such health care services. The term also
46 includes any health insurer's or utilization review entity's
47 requirement that an insured or health care provider notify the
48 health insurer or utilization review entity before providing a
49 health care service.
50 (e) "Urgent health care service" means a health care

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51 service with respect to which the application of the time
52 periods for making a nonexpedited prior authorization, in the
53 opinion of a physician with knowledge of the patient's medical
54 condition, could:
55 1. Seriously jeopardize the life or health of the patient
56 or the ability of the patient to regain maximum function; or
57 2. Subject the patient to severe pain that cannot be
58 adequately managed without the care, treatment, or prescription
59 drugs that are the subject of the prior authorization request.
60 (f) "Utilization review entity" ~~"health insurer"~~ means an
61 authorized insurer offering health insurance as defined in s.
62 624.603, a managed care plan as defined in s. 409.962(10), ~~or~~ a
63 health maintenance organization as defined in s. 641.19(12), a
64 pharmacy benefit manager as defined in s. 624.490(1), or any
65 other individual or entity that provides, offers to provide, or
66 administers hospital, outpatient, medical, prescription drug, or
67 other health benefits to a person treated by a health care
68 provider in the state under a policy, plan, or contract.
69 (2) Beginning January 1, 2024, a utilization review entity
70 must establish a secure, interactive online electronic prior
71 authorization process for accepting electronic prior
72 authorization requests. The process must allow a person seeking
73 prior authorization to upload documentation if such
74 documentation is required by the utilization review entity to
75 adjudicate the prior authorization request.

76 (3)~~(2)~~ Notwithstanding any other provision of law,
77 effective January 1, 2017, or 6 ~~six (6)~~ months after the
78 effective date of the rule adopting the prior authorization
79 form, whichever is later, a utilization review entity that ~~a~~
80 ~~health insurer, or a pharmacy benefits manager on behalf of the~~
81 ~~health insurer, which~~ does not provide an electronic prior
82 authorization process for use by its contracted providers~~,~~ shall
83 ~~only~~ use only the prior authorization form that has been
84 approved by the Financial Services Commission for granting a
85 prior authorization for a medical procedure, course of
86 treatment, or prescription drug benefit. Such form may not
87 exceed two pages in length, excluding any instructions or
88 guiding documentation, and must include all clinical
89 documentation necessary for the utilization review entity ~~health~~
90 ~~insurer~~ to make a decision. At a minimum, the form must include:
91 (1) sufficient patient information to identify the member, date
92 of birth, full name, and Health Plan ID number; (2) provider
93 name, address and phone number; (3) the medical procedure,
94 course of treatment, or prescription drug benefit being
95 requested, including the medical reason therefor, and all
96 services tried and failed; (4) any laboratory documentation
97 required; and (5) an attestation that all information provided
98 is true and accurate.
99 (4)~~(3)~~ The Financial Services Commission in consultation
100 with the Agency for Health Care Administration shall adopt by

101 rule guidelines for all prior authorization forms which ensure
102 the general uniformity of such forms.
103 (5) ~~(4)~~ Electronic prior authorization approvals do not
104 preclude benefit verification or medical review by the insurer
105 under either the medical or pharmacy benefits.
106 (6) A utilization review entity's prior authorization
107 process may not require information that is not needed to make a
108 determination or facilitate a determination of medical necessity
109 of the requested medical procedure, course of treatment, or
110 prescription drug benefit.
111 (7) A utilization review entity shall disclose all of its
112 prior authorization requirements and restrictions, including any
113 written clinical criteria, on its website in a manner that is
114 readily accessible to the public. This information shall be
115 explained in detail and in clear and unambiguous language.
116 (8) A utilization review entity may not implement any new
117 requirements or restrictions or make changes to existing
118 requirements or restrictions on obtaining prior authorization
119 unless:
120 (a) The changes have been available on a publicly
121 accessible website for at least 60 days before being
122 implemented.
123 (b) Insureds and health care providers who are affected by
124 the new requirements and restrictions or changes to the
125 requirements and restrictions are provided with a written notice

126 of the changes at least 60 days before being implemented. Such
127 notice must be delivered electronically or by other means as
128 agreed to by the insured or the health care provider.
129 (9) A utilization review entity shall make statistics
130 available regarding prior authorization approvals and denials on
131 its website in a manner that is readily accessible to the
132 public. The statistics must include categories for:
133 (a) Physician specialty.
134 (b) Medication or diagnostic test or procedure.
135 (c) Indication offered.
136 (d) Reason for denial.
137 (e) Appeal.
138 (f) Approval or denial on appeal.
139 (g) The time between submission and the response.
140
141 This subsection does not apply to the expansion of health care
142 services coverage.
143 (10) A utilization review entity must ensure that all
144 adverse determinations are made by a physician licensed under
145 chapter 458 or chapter 459 who:
146 (a) Possesses a current, valid, and unrestricted license
147 to practice medicine in the state.
148 (b) Is of the same specialty as the physician who
149 typically manages the medical condition or disease or provides
150 the health care service involved in the request.

151 (c) Has experience treating patients with the medical
152 condition or disease for which the health care service is being
153 requested.
154 (11) Notice of an adverse determination shall be provided
155 by electronic mail to the insured and the health care provider
156 that initiated the prior authorization. Notice required under
157 this subsection must include:
158 (a) The name, title, e-mail address, and telephone number
159 of the physician responsible for making the adverse
160 determination.
161 (b) The written clinical criteria, if any, and any
162 internal rule, guideline, or protocol on which the utilization
163 review entity relied when making the adverse determination and
164 how those provisions apply to the insured's specific medical
165 circumstance.
166 (c) Information for the insured and the insured's health
167 care provider which describes the procedure through which the
168 insured or health care provider may request a copy of any report
169 developed by personnel performing the review that led to the
170 adverse determination.
171 (d) Information that explains to the insured and the
172 insured's healthcare provider how to appeal the adverse
173 determination.
174 (12) If a utilization review entity requires prior
175 authorization of a nonurgent health care service, the

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176 utilization review entity shall make an authorization or adverse
177 determination and notify the insured and the insured's health
178 care provider of the decision within 2 business days after
179 obtaining all necessary information to make the authorization or
180 adverse determination. As used in this subsection, the term
181 "necessary information" includes the results of any face-to-face
182 clinical evaluation or second opinion that may be required.
183 (13) A utilization review entity shall render an expedited
184 authorization or adverse determination concerning an urgent
185 health care service and notify the insured and the insured's
186 health care provider of that expedited prior authorization or
187 adverse determination no later than 1 business day after
188 receiving all information needed to complete the review of the
189 requested urgent healthcare service.
190 (14) A utilization review entity may not require prior
191 authorization for prehospital transportation or for provision of
192 an emergency health care service.
193 (15) A utilization review entity may not require prior
194 authorization for the provision of medications for opioid use
195 disorder. As used in this subsection, the term "medications for
196 opioid use disorder" means the use of United States Food and
197 Drug Administration approved medications, commonly in
198 combination with counseling and behavioral therapies, to provide
199 a comprehensive approach to the treatment of opioid use
200 disorder. Food and Drug Administration approved medications used

201 to treat opioid addiction include, but are not limited to,
202 methadone, buprenorphine, alone or in combination with naloxone,
203 and extended-release injectable naltrexone. Types of behavioral
204 therapies include, but are not limited to, individual therapy,
205 group counseling, family behavior therapy, motivational
206 incentives, and other modalities.
207 (16) A utilization review entity may not revoke, limit,
208 condition, or restrict a prior authorization if care is provided
209 within 45 business days after the date the health care provider
210 received the prior authorization. A utilization review entity
211 must pay the health care provider at the contracted payment rate
212 for a health care service provided by the health care provider
213 per prior authorization unless:
214 (a) The health care provider knowingly and materially
215 misrepresented the health care service in the prior
216 authorization request with the specific intent to deceive and
217 obtain an unlawful payment from the utilization review entity;
218 (b) The health care service was no longer a covered
219 benefit on the day it was provided, and the utilization review
220 entity notified the health care provider in writing of this fact
221 before the health care service was provided;
222 (c) The health care provider was no longer contracted with
223 the insured's health insurance plan on the date the care was
224 provided, and the utilization review entity notified the health
225 care provider in writing of this fact before the health care

226 service was provided;
227 (d) The health care provider failed to meet the
228 utilization review entity's timely filing requirements;
229 (e) The authorized service was never performed; or
230 (f) The patient was no longer eligible for health care
231 coverage on the day the care was provided, and the utilization
232 review entity notified the health care provider in writing of
233 this fact before the health care service was provided.
234 (17) If a utilization review entity required a prior
235 authorization for a health care service for the treatment of a
236 chronic or long-term care condition, the prior authorization
237 remains valid for the length of the treatment and the
238 utilization review entity may not require the insured to obtain
239 a prior authorization again for the health care service.
240 (18) A utilization review entity may not impose an
241 additional prior authorization requirement with respect to a
242 surgical or otherwise invasive procedure, or any item provided
243 as part of the surgical or invasive procedure, if the procedure
244 or item is provided during the perioperative period of another
245 procedure for which prior authorization was granted by the
246 health insurer.
247 (19) If there is a change in coverage or approval criteria
248 for a previously authorized health care service, the change in
249 coverage or approval criteria may not affect an insured who
250 received prior authorization before the effective date of the

251 change for the remainder of the insured's policy, plan, or
252 contract year.
253 (20) A utilization review entity shall continue to honor a
254 prior authorization that it has granted to an insurer when the
255 insurer changes products under the same health insurer.
256 (21) A failure by a utilization review entity to comply
257 with the deadlines and other requirements of this section will
258 result in a health care service subject to review to be
259 automatically deemed authorized by the utilization review
260 entity.
261 (22) The provisions of this section may not be waived by
262 any policy, plan, or contract. Any policy, plan, or contractual
263 arrangements or any actions taken in conflict with this section
264 or that purport to waive any requirements of this section are
265 void.
266 Section 2. This act shall take effect July 1, 2023.