First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 19-0894.01 Christy Chase x2008 **HOUSE BILL 19-1211**

HOUSE SPONSORSHIP

Michaelson Jenet,

SENATE SPONSORSHIP

(None),

House Committees
Health & Insurance

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING PRIOR AUTHORIZATION REQUESTS SUBMITTED BY**
102 **PROVIDERS FOR A DETERMINATION OF COVERAGE OF HEALTH**
103 **CARE SERVICES UNDER A HEALTH BENEFIT PLAN.**

Bill Summary

(Note: ghThis summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

With regard to the prior authorization process used by carriers or private utilization review organizations (organizations) acting on behalf of carriers to review and determine whether a particular health care service prescribed by a health care provider is approved as a covered benefit under the patient's health benefit plan, the bill requires carriers

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

and organizations to:

- Publish and update their prior authorization requirements and restrictions;
- Comply with deadlines established in the bill for making a determination on a prior authorization request;
- Use current, clinically based prior authorization criteria that are aligned with other quality initiatives of the carrier or organization and with other carriers' and organizations' prior authorization criteria for the same health care service;
- Limit the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors; and
- Exempt from prior authorization providers with an 80% approval rate of prior authorization requests over the previous 12 months, and conduct annual reevaluation of a provider's eligibility for the exemption.

If a carrier or organization fails to make a determination within the time required or fails to apply prior authorization requirements or exempt providers from prior authorization requirements, the request is deemed approved.

An approved prior authorization request is valid for at least 180 days and continues for the duration of the prescribed or ordered course of treatment and the covered person's plan year.

The commissioner of insurance is authorized to adopt rules as necessary to implement the bill.

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1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1. Legislative declaration.** (1) The general assembly

3 finds and declares that:

4 (a) The provider-patient relationship is paramount and should not

5 be subject to intrusion by a third party;

6 (b) Prior authorization programs can prioritize potential cost

7 savings ahead of optimal patient care;

8 (c) Prior authorization programs should not be permitted to hinder

9 patient care or intrude on the practice of a health care profession; and

10 (d) Prior authorization programs must include the use of written,

1 clinical criteria and reviews by appropriate providers to ensure a fair
2 process for patients.
3 **SECTION 2.** In Colorado Revised Statutes, **add** 10-16-112.5 as
4 follows:
5 **10-16-112.5. Prior authorization for health care services -**
6 **disclosures and notice - determination deadlines - criteria - limits and**
7 **exceptions - definitions - rules.** (1) **Applicability.** (a) ON OR AFTER
8 JANUARY 1, 2020, A CARRIER OR, IF A CARRIER CONTRACTS WITH A
9 PRIVATE UTILIZATION REVIEW ORGANIZATION TO PERFORM PRIOR
10 AUTHORIZATION FOR HEALTH CARE SERVICES, THE ORGANIZATION SHALL
11 USE THE PRIOR AUTHORIZATION PROCESS AND COMPLY WITH THE
12 REQUIREMENTS SPECIFIED IN THIS SECTION. EXCEPT AS OTHERWISE
13 SPECIFIED IN THIS SECTION, THIS SECTION APPLIES TO PRIOR
14 AUTHORIZATION REQUESTS FOR HEALTH CARE SERVICES, INCLUDING
15 REQUESTS FOR DRUG BENEFITS.
16 (b) THIS SECTION DOES NOT APPLY TO A NONPROFIT HEALTH
17 MAINTENANCE ORGANIZATION WITH RESPECT TO MANAGED CARE PLANS
18 THAT PROVIDE A MAJORITY OF COVERED PROFESSIONAL SERVICES
19 THROUGH A SINGLE CONTRACTED MEDICAL GROUP.
20 (2) **Disclosure of requirements - notice of changes.** (a) (I) A
21 CARRIER SHALL MAKE CURRENT PRIOR AUTHORIZATION REQUIREMENTS
22 AND RESTRICTIONS, INCLUDING WRITTEN, CLINICAL CRITERIA, READILY
23 ACCESSIBLE ON THE CARRIER'S WEBSITE. THE PRIOR AUTHORIZATION
24 REQUIREMENTS MUST BE DESCRIBED IN DETAIL AND IN CLEAR AND EASILY
25 UNDERSTANDABLE LANGUAGE.
26 (II) IF A CARRIER CONTRACTS WITH A PRIVATE UTILIZATION
27 REVIEW ORGANIZATION TO PERFORM PRIOR AUTHORIZATION FOR HEALTH

1 CARE SERVICES, THE ORGANIZATION SHALL PROVIDE ITS PRIOR
2 AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, AS REQUIRED BY THIS
3 SUBSECTION (2), TO THE CARRIER WITH WHOM THE ORGANIZATION
4 CONTRACTED, AND THAT CARRIER SHALL POST THE ORGANIZATION'S PRIOR
5 AUTHORIZATION REQUIREMENTS AND RESTRICTIONS ON ITS WEBSITE.
6 (b) IF A CARRIER OR ORGANIZATION INTENDS TO IMPLEMENT A NEW
7 PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION OR TO AMEND AN
8 EXISTING REQUIREMENT OR RESTRICTION, THE CARRIER OR ORGANIZATION
9 SHALL:
10 (I) NOTIFY ANY PARTICIPATING PROVIDERS OF THE NEW OR
11 AMENDED REQUIREMENT OR RESTRICTION IN THE MANNER AND WITHIN
12 THE TIME SPECIFIED IN SECTION 25-37-104 (1); AND
13 (II) UPDATE THE PRIOR AUTHORIZATION INFORMATION POSTED ON
14 THE CARRIER'S WEBSITE PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION
15 TO REFLECT THE NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT
16 OR RESTRICTION BEFORE IMPLEMENTING THE NEW OR AMENDED
17 REQUIREMENT OR RESTRICTION.
18 (c) (I) A CARRIER SHALL POST ON ITS WEBSITE DATA REGARDING
19 APPROVALS AND DENIALS OF PRIOR AUTHORIZATION REQUESTS IN A
20 READILY ACCESSIBLE FORMAT AND THAT INCLUDE THE FOLLOWING
21 CATEGORIES:
22 (A) PROVIDER SPECIALTY;
23 (B) MEDICATION OR DIAGNOSTIC TEST OR PROCEDURE;
24 (C) REASON FOR DENIAL; AND
25 (D) DENIALS OVERTURNED ON APPEAL.
26 (II) AN ORGANIZATION THAT PROVIDES PRIOR AUTHORIZATION FOR
27 A CARRIER SHALL PROVIDE THE DATA SPECIFIED IN SUBSECTION (2)(c)(I)

1 OF THIS SECTION TO THE CARRIER WITH WHOM THE ORGANIZATION
2 CONTRACTED, AND THE CARRIER SHALL POST THE ORGANIZATION'S DATA
3 ON ITS WEBSITE.
4 (III) CARRIERS AND ORGANIZATIONS SHALL USE THE DATA
5 SPECIFIED IN THIS SUBSECTION (2)(c) TO REFINE AND IMPROVE THEIR
6 UTILIZATION MANAGEMENT PROGRAMS.
7 (3) **Nonurgent, urgent, and emergency health care services -**
8 **timely determination - notice of determination - deemed approved.**
9 (a) EXCEPT AS PROVIDED IN SUBSECTION (3)(b) OF THIS SECTION, A PRIOR
10 AUTHORIZATION REQUEST IS DEEMED GRANTED IF A CARRIER OR
11 ORGANIZATION FAILS TO:
12 (I) (A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO
13 BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS
14 APPROVED, DENIED, OR INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE
15 SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED
16 PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO
17 PROCESS THE REQUEST; OR
18 (B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO
19 BUSINESS DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION
20 REQUIRED BY THE CARRIER OR ORGANIZATION PURSUANT TO SUBSECTION
21 (3)(a)(I)(A) OF THIS SECTION, THAT THE REQUEST IS APPROVED OR DENIED;
22 (II) FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT HEALTH
23 CARE SERVICES:
24 (A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN ONE
25 CALENDAR DAY AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS
26 APPROVED, DENIED, OR INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE
27 SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED

1 PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO
2 PROCESS THE REQUEST; OR
3 (B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN ONE
4 CALENDAR DAY AFTER RECEIVING THE ADDITIONAL INFORMATION
5 REQUIRED BY THE CARRIER OR ORGANIZATION PURSUANT TO SUBSECTION
6 (3)(a)(II)(A) OF THIS SECTION, THAT THE REQUEST IS APPROVED OR
7 DENIED; AND
8 (III) FOR A PRIOR AUTHORIZATION REQUEST FOR IMMEDIATE
9 EVALUATION OR STABILIZATION SERVICES REQUIRED FOLLOWING THE
10 PROVISION OF EMERGENCY SERVICES TO A COVERED PERSON, IF THE
11 POST-EVALUATION OR POST-STABILIZATION SERVICES ARE SUBJECT TO
12 PRIOR AUTHORIZATION, NOTIFY THE PROVIDER AND COVERED PERSON,
13 WITHIN SIXTY MINUTES AFTER RECEIVING THE REQUEST, THAT THE
14 REQUEST IS APPROVED OR DENIED.
15 (b) IF A CARRIER OR ORGANIZATION NOTIFIES THE PROVIDER AND
16 COVERED PERSON PURSUANT TO SUBSECTION (3)(a)(I)(A) OR (3)(a)(II)(A)
17 OF THIS SECTION THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE
18 AND THAT ADDITIONAL INFORMATION IS REQUIRED, THE PROVIDER SHALL
19 SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS
20 AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR ORGANIZATION. IF
21 THE PROVIDER FAILS TO SUBMIT THE REQUIRED ADDITIONAL INFORMATION
22 WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST
23 IS NOT DEEMED GRANTED PURSUANT TO SUBSECTION (3)(a) OF THIS
24 SECTION. AFTER RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION,
25 THE CARRIER OR ORGANIZATION SHALL RESPOND TO THE PRIOR
26 AUTHORIZATION REQUEST IN ACCORDANCE WITH SUBSECTION (3)(a)(I)(B)
27 OF THIS SECTION OR, FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT

1 HEALTH CARE SERVICES, SUBSECTION (3)(a)(II)(B) OF THIS SECTION.

2 (c) AS SPECIFIED IN SECTION 10-16-704 (5.5)(a)(I), PRIOR
3 AUTHORIZATION IS NOT REQUIRED FOR EMERGENCY SERVICES.
4 EMERGENCY SERVICES NECESSARY TO SCREEN AND STABILIZE A COVERED
5 PERSON MUST BE COVERED.

6 (d) (I) WHEN NOTIFYING THE PROVIDER OF THE DETERMINATION
7 ON A PRIOR AUTHORIZATION REQUEST, THE CARRIER OR ORGANIZATION
8 SHALL PROVIDE A UNIQUE PRIOR AUTHORIZATION NUMBER ATTRIBUTABLE
9 TO THAT REQUEST AND THE PARTICULAR HEALTH CARE SERVICE THAT IS
10 THE SUBJECT OF THE REQUEST.

11 (II) IF THE CARRIER OR ORGANIZATION DENIES A PRIOR
12 AUTHORIZATION REQUEST, THE NOTICE OF THE DENIAL MUST COMPLY
13 WITH THE REQUIREMENTS OF SECTION 10-16-113 (2) AND COMMISSIONER
14 RULES ADOPTED PURSUANT TO THAT SECTION AND ALSO INCLUDE
15 INFORMATION CONCERNING WHETHER THE CARRIER OR ORGANIZATION
16 REQUIRES AN ALTERNATIVE TREATMENT, TEST, PROCEDURE, OR
17 MEDICATION.

18 (e) THIS SUBSECTION (3) DOES NOT APPLY TO PRIOR
19 AUTHORIZATION REQUESTS FOR DRUG BENEFITS THAT ARE SUBJECT TO
20 SECTION 10-16-124.5; EXCEPT THAT SUBSECTION (3)(d)(II) OF THIS
21 SECTION APPLIES TO PRIOR AUTHORIZATION REQUESTS FOR DRUG
22 BENEFITS.

23 (4) **Criteria, limits, and exceptions.** (a) CARRIERS AND
24 ORGANIZATIONS SHALL:

25 (I) USE PRIOR AUTHORIZATION CRITERIA THAT ARE CURRENT,
26 CLINICALLY BASED, ALIGNED WITH OTHER QUALITY INITIATIVES OF THE
27 CARRIER OR ORGANIZATION, AND ALIGNED WITH OTHER CARRIERS' AND

1 ORGANIZATIONS' PRIOR AUTHORIZATION CRITERIA FOR THE SAME HEALTH
2 CARE SERVICES;
3 (II) ENSURE THAT PRIOR AUTHORIZATION REQUESTS ARE
4 REVIEWED BY APPROPRIATE PROVIDERS; AND
5 (III) MAKE ELIGIBILITY, BENEFIT COVERAGE, AND MEDICAL POLICY
6 DETERMINATIONS AS PART OF THE PRIOR AUTHORIZATION PROCESS.
7 (b) (I) CARRIERS AND ORGANIZATIONS SHALL LIMIT THE USE OF
8 PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR ORDERING
9 PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS
10 AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS.
11 (II) (A) A CARRIER OR ORGANIZATION SHALL EXEMPT FROM PRIOR
12 AUTHORIZATION REQUIREMENTS A PROVIDER THAT HAS AT LEAST AN
13 EIGHTY PERCENT APPROVAL RATE OF PRIOR AUTHORIZATION REQUESTS
14 OVER THE IMMEDIATELY PRECEDING TWELVE MONTHS. AT LEAST
15 ANNUALLY, A CARRIER OR ORGANIZATION SHALL REEXAMINE A
16 PROVIDER'S PRESCRIBING OR ORDERING PATTERNS AND REEVALUATE THE
17 PROVIDER'S STATUS FOR EXEMPTION FROM PRIOR AUTHORIZATION
18 REQUIREMENTS PURSUANT TO THIS SUBSECTION (4)(b)(II).
19 (B) THE CARRIER OR ORGANIZATION SHALL INFORM THE PROVIDER
20 OF THE PROVIDER'S EXEMPTION STATUS AND PROVIDE INFORMATION ON
21 THE DATA CONSIDERED AS PART OF ITS REEXAMINATION OF THE
22 PROVIDER'S PRESCRIBING OR ORDERING PATTERNS FOR THE
23 TWELVE-MONTH PERIOD OF REVIEW.
24 (c) IF A CARRIER OR ORGANIZATION FAILS TO COMPLY WITH THIS
25 SUBSECTION (4) WITH REGARD TO A PARTICULAR PRIOR AUTHORIZATION
26 REQUEST, THE REQUEST IS DEEMED APPROVED.
27 (5) **Duration of approval.** (a) UPON APPROVAL BY THE CARRIER

1 OR ORGANIZATION, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE
2 HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL AND CONTINUES
3 FOR THE DURATION OF THE PRESCRIBED OR ORDERED COURSE OF
4 TREATMENT. EXCEPT AS PROVIDED IN SUBSECTION (5)(b) OF THIS SECTION,
5 ONCE APPROVED, A CARRIER OR ORGANIZATION SHALL NOT
6 RETROACTIVELY DENY THE PRIOR AUTHORIZATION REQUEST FOR A HEALTH
7 CARE SERVICE.
8 (b) IF THERE IS A CHANGE IN STATUS OF A PREVIOUSLY APPROVED
9 HEALTH CARE SERVICE, THE CHANGE IN THE STATUS OF THE PREVIOUSLY
10 APPROVED HEALTH CARE SERVICE DOES NOT AFFECT A COVERED PERSON
11 WHO RECEIVED PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF
12 THE CHANGE FOR THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR.
13 (6) **Rules.** THE COMMISSIONER MAY ADOPT RULES AS NECESSARY
14 TO IMPLEMENT THIS SECTION.
15 (7) **Definitions.** AS USED IN THIS SECTION:
16 (a) "APPROVAL" MEANS A DETERMINATION BY A CARRIER OR
17 ORGANIZATION THAT A HEALTH CARE SERVICE HAS BEEN REVIEWED AND,
18 BASED ON THE INFORMATION PROVIDED, SATISFIES THE CARRIER'S OR
19 ORGANIZATION'S REQUIREMENTS FOR MEDICAL NECESSITY AND
20 APPROPRIATENESS AND THAT PAYMENT WILL BE MADE FOR THAT HEALTH
21 CARE SERVICE.
22 (b) "CLINICAL CRITERIA" MEANS THE WRITTEN POLICIES, WRITTEN
23 SCREENING PROCEDURES, DRUG FORMULARIES OR LISTS OF COVERED
24 DRUGS, DETERMINATION RULES, DETERMINATION ABSTRACTS, CLINICAL
25 PROTOCOLS, PRACTICE GUIDELINES, MEDICAL PROTOCOLS, AND OTHER
26 CRITERIA OR RATIONALE USED BY THE CARRIER OR ORGANIZATION TO
27 DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE

1 SERVICES.

2 (c) "MEDICAL NECESSITY" MEANS A DETERMINATION THAT A
3 PRUDENT PROVIDER WOULD PROVIDE A PARTICULAR HEALTH CARE
4 SERVICE TO A PATIENT FOR THE PURPOSE OF PREVENTING, DIAGNOSING, OR
5 TREATING AN ILLNESS, INJURY, DISEASE, OR SYMPTOM IN A MANNER THAT
6 IS:

7 (I) IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF
8 MEDICAL PRACTICE;

9 (II) CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY,
10 EXTENT, SITE, AND DURATION; AND

11 (III) NOT PRIMARILY FOR THE ECONOMIC BENEFIT OF CARRIERS
12 AND PURCHASERS OR FOR THE CONVENIENCE OF THE PATIENT, TREATING
13 PROVIDER, OR OTHER PROVIDER.

14 (d) "PRIOR AUTHORIZATION" MEANS THE PROCESS BY WHICH A
15 CARRIER OR ORGANIZATION DETERMINES THE MEDICAL NECESSITY AND
16 APPROPRIATENESS OF OTHERWISE COVERED HEALTH CARE SERVICES PRIOR
17 TO THE RENDERING OF THE SERVICES. "PRIOR AUTHORIZATION" INCLUDES
18 PREADMISSION REVIEW, PRETREATMENT REVIEW, UTILIZATION REVIEW,
19 AND CASE MANAGEMENT AND A CARRIER'S OR ORGANIZATION'S
20 REQUIREMENT THAT A COVERED PERSON OR PROVIDER NOTIFY THE
21 CARRIER OR ORGANIZATION PRIOR TO RECEIVING OR PROVIDING A HEALTH
22 CARE SERVICE.

23 (e) "PRIVATE UTILIZATION REVIEW ORGANIZATION" OR
24 "ORGANIZATION" HAS THE SAME MEANING AS SET FORTH IN SECTION
25 10-16-112 (1)(a).

26 (f) "URGENT HEALTH CARE SERVICE" MEANS A HEALTH CARE
27 SERVICE THAT, IN THE OPINION OF THE PROVIDER BASED ON THE COVERED

1 PERSON'S MEDICAL CONDITION, IF SUBJECTED TO THE PRIOR
2 AUTHORIZATION TIME PERIOD FOR A NONURGENT HEALTH CARE SERVICE,
3 COULD:
4 (I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED
5 PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM
6 FUNCTION; OR
7 (II) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT CANNOT
8 BE ADEQUATELY MANAGED WITHOUT THE PARTICULAR HEALTH CARE
9 SERVICE.
10 **SECTION 3.** In Colorado Revised Statutes, 10-16-112, **amend**
11 (1)(a) as follows:
12 **10-16-112. Private utilization review - health care coverage**
13 **entity responsibility.** (1) As used in this section, unless the context
14 otherwise requires:
15 (a) "Private utilization review organization" means an entity, other
16 than a hospital or public reviewer following federal guidelines, ~~which~~
17 THAT conducts utilization review OR REVIEWS AND MAKES
18 DETERMINATIONS ON PRIOR AUTHORIZATION REQUESTS FOR HEALTH CARE
19 SERVICES AS DESCRIBED IN SECTION 10-16-112.5. This definition shall not
20 apply to any independent medical examination provided for in any policy
21 of insurance.
22 **SECTION 4. Act subject to petition - effective date -**
23 **applicability.** (1) This act takes effect at 12:01 a.m. on the day following
24 the expiration of the ninety-day period after final adjournment of the
25 general assembly (August 2, 2019, if adjournment sine die is on May 3,
26 2019); except that, if a referendum petition is filed pursuant to section 1
27 (3) of article V of the state constitution against this act or an item, section,

1 or part of this act within such period, then the act, item, section, or part
2 will not take effect unless approved by the people at the general election
3 to be held in November 2020 and, in such case, will take effect on the
4 date of the official declaration of the vote thereon by the governor.
5 (2) This act applies to prior authorization requests for health care
6 services submitted on or after January 1, 2020.