First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

REENGROSSED

This Version Includes All Amendments Adopted in the House of Introduction

LLS NO. 19-0894.01 Christy Chase x2008

HOUSE BILL 19-1211

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A BILL FOR AN ACT

CONCERNING PRIOR AUTHORIZATION REQUESTS SUBMITTED BY PROVIDERS FOR A DETERMINATION OF COVERAGE OF HEALTH 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

HOUSE
3rd Reading Unamended
April 1, 2019

HOUSE
Amended 2nd Reading
March 29, 2019

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.

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

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) The provider-patient relationship is paramount and should not be subject to intrusion by a third party;

(b) Prior authorization programs can prioritize potential cost savings ahead of optimal patient care;

(c) Prior authorization programs should not be permitted to hinder patient care or intrude on the practice of a health care profession; and

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

clinical criteria and reviews by appropriate providers to ensure a fair process for patients.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-112.5 as follows:

10-16-112.5. Prior authorization for health care services - disclosures and notice - determination deadlines - criteria - limits and exceptions - definitions - rules. (1) **Applicability.** (a) ON OR AFTER JANUARY 1, 2020, A CARRIER OR, IF A CARRIER CONTRACTS WITH A PRIVATE UTILIZATION REVIEW ORGANIZATION TO PERFORM PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES, THE ORGANIZATION SHALL USE THE PRIOR AUTHORIZATION PROCESS AND COMPLY WITH THE REQUIREMENTS SPECIFIED IN THIS SECTION. EXCEPT AS OTHERWISE SPECIFIED IN THIS SECTION, THIS SECTION APPLIES TO PRIOR AUTHORIZATION REQUESTS FOR HEALTH CARE SERVICES, EXCLUDING REQUESTS FOR DRUG BENEFITS PURSUANT TO SECTION 10-16-124.5.

(b) THIS SECTION DOES NOT APPLY TO:

(I) A NONPROFIT HEALTH MAINTENANCE ORGANIZATION WITH RESPECT TO MANAGED CARE PLANS THAT PROVIDE A MAJORITY OF COVERED PROFESSIONAL SERVICES THROUGH A SINGLE CONTRACTED MEDICAL GROUP;

(II) A NONPROFIT HEALTH MAINTENANCE ORGANIZATION OPERATED BY OR UNDER THE CONTROL OF THE DENVER HEALTH AND HOSPITAL AUTHORITY CREATED BY ARTICLE 29 OF TITLE 25 OR ANY SUBSIDIARY OF THE AUTHORITY; OR

(III) CARRIERS, ORGANIZATIONS, AND MEDICAL BENEFITS SUBJECT TO THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO 47 OF TITLE 8.

(2) **Disclosure of requirements - notice of changes.** (a) (I) A CARRIER SHALL MAKE CURRENT PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, INCLUDING WRITTEN, CLINICAL CRITERIA, READILY ACCESSIBLE ON THE CARRIER'S WEBSITE. THE PRIOR AUTHORIZATION REQUIREMENTS MUST BE DESCRIBED IN DETAIL AND IN CLEAR AND EASILY UNDERSTANDABLE LANGUAGE.

(II) IF A CARRIER CONTRACTS WITH A PRIVATE UTILIZATION REVIEW ORGANIZATION TO PERFORM PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES, THE ORGANIZATION SHALL PROVIDE ITS PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, AS REQUIRED BY THIS SUBSECTION (2), TO THE CARRIER WITH WHOM THE ORGANIZATION CONTRACTED, AND THAT CARRIER SHALL POST THE ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS ON ITS WEBSITE.

(III) WHEN POSTING PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS PURSUANT TO THIS SUBSECTION (2)(a) OR SUBSECTION (2)(b) OF THIS SECTION, A CARRIER IS NEITHER REQUIRED TO POST NOR PROHIBITED FROM POSTING THE PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS ON A PUBLIC-FACING PORTION OF ITS WEBSITE.

(b) IF A CARRIER OR ORGANIZATION INTENDS TO IMPLEMENT A NEW PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION OR TO AMEND AN EXISTING REQUIREMENT OR RESTRICTION, THE CARRIER OR ORGANIZATION SHALL:

(I) NOTIFY ANY PARTICIPATING PROVIDERS OF THE NEW OR AMENDED REQUIREMENT OR RESTRICTION IN THE MANNER AND WITHIN THE TIME SPECIFIED IN SECTION 25-37-102 (9)(c) OR 25-37-104 (1), AS APPLICABLE; AND

(II) UPDATE THE PRIOR AUTHORIZATION INFORMATION POSTED ON

THE CARRIER'S WEBSITE PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION TO REFLECT THE NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION BEFORE IMPLEMENTING THE NEW OR AMENDED REQUIREMENT OR RESTRICTION.

(c) (I) A CARRIER SHALL POST, ON A PUBLIC-FACING PORTION OF ITS WEBSITE, DATA REGARDING APPROVALS AND DENIALS OF PRIOR AUTHORIZATION REQUESTS, INCLUDING REQUESTS FOR DRUG BENEFITS PURSUANT TO SECTION 10-16-124.5, IN A READILY ACCESSIBLE FORMAT AND THAT INCLUDE THE FOLLOWING CATEGORIES, IN THE AGGREGATE:

(A) PROVIDER SPECIALTY;

(B) MEDICATION OR DIAGNOSTIC TEST OR PROCEDURE;

(C) REASON FOR DENIAL; AND

(D) DENIALS SPECIFIED UNDER SUBSECTION (2)(c)(I)(C) OF THIS SECTION THAT ARE OVERTURNED ON APPEAL.

(II) AN ORGANIZATION THAT PROVIDES PRIOR AUTHORIZATION FOR A CARRIER SHALL PROVIDE THE DATA SPECIFIED IN SUBSECTION (2)(c)(I) OF THIS SECTION TO THE CARRIER WITH WHOM THE ORGANIZATION CONTRACTED, AND THE CARRIER SHALL POST THE ORGANIZATION'S DATA ON ITS WEBSITE.

(III) CARRIERS AND ORGANIZATIONS SHALL USE THE DATA SPECIFIED IN THIS SUBSECTION (2)(c) TO REFINE AND IMPROVE THEIR UTILIZATION MANAGEMENT PROGRAMS.

(3) **Nonurgent and urgent health care services - timely determination - notice of determination - deemed approved.** (a) EXCEPT AS PROVIDED IN SUBSECTION (3)(b) OF THIS SECTION, A PRIOR AUTHORIZATION REQUEST IS DEEMED GRANTED IF A CARRIER OR ORGANIZATION FAILS TO:

(I) (A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN FIVE BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED, DENIED, OR INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE REQUEST; OR

(B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN FIVE BUSINESS DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE CARRIER OR ORGANIZATION PURSUANT TO SUBSECTION (3)(a)(I)(A) OF THIS SECTION, THAT THE REQUEST IS APPROVED OR DENIED; AND

(II) FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT HEALTH CARE SERVICES:

(A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO BUSINESS DAYS BUT NOT LONGER THAN SEVENTY-TWO HOURS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED, DENIED, OR INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE REQUEST; OR

(B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO BUSINESS DAYS BUT NOT LONGER THAN SEVENTY-TWO HOURS AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE CARRIER OR ORGANIZATION PURSUANT TO SUBSECTION (3)(a)(II)(A) OF THIS SECTION, THAT THE REQUEST IS APPROVED OR DENIED.

(b) IF A CARRIER OR ORGANIZATION NOTIFIES THE PROVIDER AND COVERED PERSON PURSUANT TO SUBSECTION (3)(a)(I)(A) OR (3)(a)(II)(A)

OF THIS SECTION THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE AND THAT ADDITIONAL INFORMATION IS REQUIRED, THE PROVIDER SHALL SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR ORGANIZATION. IF THE PROVIDER FAILS TO SUBMIT THE REQUIRED ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST IS NOT DEEMED GRANTED PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION. AFTER RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION, THE CARRIER OR ORGANIZATION SHALL RESPOND TO THE PRIOR AUTHORIZATION REQUEST IN ACCORDANCE WITH SUBSECTION (3)(a)(I)(B) OF THIS SECTION OR, FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT HEALTH CARE SERVICES, SUBSECTION (3)(a)(II)(B) OF THIS SECTION.

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

(II) IF THE CARRIER OR ORGANIZATION DENIES A PRIOR AUTHORIZATION REQUEST BASED ON A GROUND SPECIFIED IN SECTION 10-16-113 (3)(a), THE NOTIFICATION IS SUBJECT TO THE REQUIREMENTS OF SECTION 10-16-113 (3)(a) AND COMMISSIONER RULES ADOPTED PURSUANT TO THAT SECTION AND MUST INCLUDE INFORMATION CONCERNING WHETHER THE CARRIER OR ORGANIZATION REQUIRES AN ALTERNATIVE TREATMENT, TEST, PROCEDURE, OR MEDICATION.

(d) THIS SUBSECTION (3) DOES NOT APPLY TO PRIOR AUTHORIZATION REQUESTS FOR DRUG BENEFITS THAT ARE SUBJECT TO

SECTION 10-16-124.5; EXCEPT THAT SUBSECTION (3)(c)(II) OF THIS SECTION APPLIES TO PRIOR AUTHORIZATION REQUESTS FOR DRUG BENEFITS.

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

(I) USE PRIOR AUTHORIZATION CRITERIA THAT ARE CURRENT, CLINICALLY BASED, ALIGNED WITH OTHER QUALITY INITIATIVES OF THE CARRIER OR ORGANIZATION, AND ALIGNED WITH OTHER CARRIERS' AND ORGANIZATIONS' PRIOR AUTHORIZATION CRITERIA FOR THE SAME HEALTH CARE SERVICES;

(II) ENSURE THAT PRIOR AUTHORIZATION REQUESTS ARE REVIEWED BY APPROPRIATE PROVIDERS; AND

(III) MAKE ELIGIBILITY, BENEFIT COVERAGE, AND MEDICAL POLICY DETERMINATIONS AS PART OF THE PRIOR AUTHORIZATION PROCESS.

(b) (I) CARRIERS AND ORGANIZATIONS SHALL CONSIDER LIMITING 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 PRESENT OPPORTUNITIES FOR IMPROVEMENT IN ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

(II) (A) A CARRIER OR ORGANIZATION MAY OFFER PROVIDERS WITH A HISTORY OF ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS AT LEAST ONE ALTERNATIVE TO PRIOR AUTHORIZATION, INCLUDING AN EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS FOR A PROVIDER THAT HAS AT LEAST AN EIGHTY PERCENT APPROVAL RATE OF PRIOR AUTHORIZATION REQUESTS OVER THE IMMEDIATELY PRECEDING TWELVE MONTHS. AT LEAST

ANNUALLY, A CARRIER OR ORGANIZATION SHALL REEXAMINE A PROVIDER'S PRESCRIBING OR ORDERING PATTERNS AND REEVALUATE THE PROVIDER'S STATUS FOR EXEMPTION FROM OR OTHER ALTERNATIVE TO PRIOR AUTHORIZATION REQUIREMENTS PURSUANT TO THIS SUBSECTION (4)(b)(II).

(B) THE CARRIER OR ORGANIZATION SHALL INFORM THE PROVIDER OF THE PROVIDER'S EXEMPTION STATUS AND PROVIDE INFORMATION ON THE DATA CONSIDERED AS PART OF ITS REEXAMINATION OF THE PROVIDER'S PRESCRIBING OR ORDERING PATTERNS FOR THE TWELVE-MONTH PERIOD OF REVIEW.

(5) **Duration of approval.** (a) UPON APPROVAL BY THE CARRIER OR ORGANIZATION, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL AND CONTINUES FOR THE DURATION OF THE AUTHORIZED COURSE OF TREATMENT. EXCEPT AS PROVIDED IN SUBSECTION (5)(b) OF THIS SECTION, ONCE APPROVED, A CARRIER OR ORGANIZATION SHALL NOT RETROACTIVELY DENY THE PRIOR AUTHORIZATION REQUEST FOR A HEALTH CARE SERVICE.

(b) IF THERE IS A CHANGE IN COVERAGE OF OR APPROVAL CRITERIA FOR A PREVIOUSLY APPROVED HEALTH CARE SERVICE, THE CHANGE IN COVERAGE OR APPROVAL CRITERIA DOES NOT AFFECT A COVERED PERSON WHO RECEIVED PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF THE CHANGE FOR THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR.

(c) SUBSECTIONS (5)(a) AND (5)(b) OF THIS SECTION DO NOT APPLY IF:

(I) THE PRIOR AUTHORIZATION APPROVAL WAS BASED ON FRAUD;

(II) THE PROVIDER NEVER PERFORMED THE SERVICES THAT WERE

REQUESTED FOR PRIOR AUTHORIZATION;

(III) THE SERVICE PROVIDED DID NOT ALIGN WITH THE SERVICE THAT WAS AUTHORIZED;

(IV) THE PERSON RECEIVING THE SERVICE NO LONGER HAD COVERAGE UNDER THE HEALTH COVERAGE PLAN ON OR BEFORE THE DATE THE SERVICE WAS DELIVERED; OR

(V) THE COVERED PERSON'S BENEFIT MAXIMUMS WERE REACHED ON OR BEFORE THE DATE THE SERVICE WAS DELIVERED.

(6) **Rules.** THE COMMISSIONER MAY ADOPT RULES AS NECESSARY TO IMPLEMENT THIS SECTION.

(7) **Definitions.** AS USED IN THIS SECTION:

(a) "APPROVAL" MEANS A DETERMINATION BY A CARRIER OR ORGANIZATION THAT A HEALTH CARE SERVICE HAS BEEN REVIEWED AND, BASED ON THE INFORMATION PROVIDED, SATISFIES THE CARRIER'S OR ORGANIZATION'S REQUIREMENTS FOR MEDICAL NECESSITY AND APPROPRIATENESS AND THAT PAYMENT WILL BE MADE FOR THAT HEALTH CARE SERVICE.

(b) "CLINICAL CRITERIA" MEANS THE WRITTEN POLICIES, WRITTEN SCREENING PROCEDURES, DRUG FORMULARIES OR LISTS OF COVERED DRUGS, DETERMINATION RULES, DETERMINATION ABSTRACTS, CLINICAL PROTOCOLS, PRACTICE GUIDELINES, MEDICAL PROTOCOLS, AND OTHER CRITERIA OR RATIONALE USED BY THE CARRIER OR ORGANIZATION TO DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE SERVICES.

(c) "MEDICAL NECESSITY" MEANS A DETERMINATION BY THE CARRIER THAT A PRUDENT PROVIDER WOULD PROVIDE A PARTICULAR COVERED HEALTH CARE SERVICE TO A PATIENT FOR THE PURPOSE OF

PREVENTING, DIAGNOSING, OR TREATING AN ILLNESS, INJURY, DISEASE, OR SYMPTOM IN A MANNER THAT IS:

(I) IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE AND APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION OR OTHER REQUIRED AGENCY;

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

(III) KNOWN TO BE EFFECTIVE IN IMPROVING HEALTH, AS PROVEN BY SCIENTIFIC EVIDENCE;

(IV) THE MOST APPROPRIATE SUPPLY, SETTING, OR LEVEL OF SERVICE THAT CAN BE SAFELY PROVIDED GIVEN THE PATIENT'S CONDITION AND THAT CANNOT BE OMITTED;

(V) NOT EXPERIMENTAL OR INVESTIGATIONAL;

(VI) NOT MORE COSTLY THAN AN ALTERNATIVE DRUG, SERVICE, SERVICE SITE, OR SUPPLY THAT IS NOT CONTRAINDICATED FOR THE PATIENT'S CONDITION OR SAFETY AND IS AT LEAST AS LIKELY TO PRODUCE EQUIVALENT THERAPEUTIC OR DIAGNOSTIC RESULTS AS TO THE DIAGNOSIS OR TREATMENT OF AN ILLNESS, INJURY, DISEASE, OR SYMPTOM; AND

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

(d) "PRIOR AUTHORIZATION" MEANS THE PROCESS BY WHICH A CARRIER OR ORGANIZATION DETERMINES THE MEDICAL NECESSITY AND APPROPRIATENESS OF OTHERWISE COVERED HEALTH CARE SERVICES PRIOR TO THE RENDERING OF THE SERVICES. "PRIOR AUTHORIZATION" INCLUDES PREADMISSION REVIEW, PRETREATMENT REVIEW, UTILIZATION REVIEW, AND CASE MANAGEMENT AND A CARRIER'S OR ORGANIZATION'S

REQUIREMENT THAT A COVERED PERSON OR PROVIDER NOTIFY THE CARRIER OR ORGANIZATION PRIOR TO RECEIVING OR PROVIDING A HEALTH CARE SERVICE.

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

(f) "URGENT HEALTH CARE SERVICE" MEANS A HEALTH CARE SERVICE THAT, IN THE OPINION OF THE PROVIDER BASED ON THE COVERED PERSON'S MEDICAL CONDITION, IF SUBJECTED TO THE PRIOR AUTHORIZATION TIME PERIOD FOR A NONURGENT HEALTH CARE SERVICE, COULD:

(I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM FUNCTION;

(II) FOR A PERSON WITH A PHYSICAL OR MENTAL DISABILITY, CREATE AN IMMINENT AND SUBSTANTIAL LIMITATION ON THE PERSON'S EXISTING ABILITY TO LIVE INDEPENDENTLY; OR

(III) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE PARTICULAR HEALTH CARE SERVICE.

SECTION 3. In Colorado Revised Statutes, 10-16-112, **amend** (1)(a) as follows:

10-16-112. Private utilization review - health care coverage entity responsibility. (1) As used in this section, unless the context otherwise requires:

(a) "Private utilization review organization" means an entity, other than a hospital or public reviewer following federal guidelines, ~~which~~

THAT conducts utilization review OR REVIEWS AND MAKES DETERMINATIONS ON PRIOR AUTHORIZATION REQUESTS FOR HEALTH CARE SERVICES AS DESCRIBED IN SECTION 10-16-112.5. This definition shall not apply to any independent medical examination provided for in any policy of insurance.

SECTION 4. Act subject to petition - effective date - applicability. (1) This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 2, 2019, if adjournment sine die is on May 3, 2019); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to prior authorization requests for health care services submitted on or after January 1, 2020.