State of Tennessee

PUBLIC CHAPTER NO. 395

HOUSE BILL NO. 885

By Representatives Hawk, Mr. Speaker Sexton, White, Terry, Moody, Helton-Haynes, Ragan

Substituted for: Senate Bill No. 666

By Senators Reeves, Mr. Speaker McNally, Massey, Pody, Stevens

AN ACT to amend Tennessee Code Annotated, Title 53; Title 56 and Title 71, relative to healthcare services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-6-702, is amended by deleting subdivisions (2) and (3) and substituting:

(2) Assure that utilization review agents adhere to reasonable standards for utilization review, including adherence to the Prior Authorization Fairness Act, compiled in chapter 7, part 36 of this title;

(3) Foster greater coordination and cooperation between healthcare providers and utilization review agents, including adherence to the Prior Authorization Fairness Act;

SECTION 2. Tennessee Code Annotated, Section 56-7-132, is amended by adding the following new subsection (f):

(f) Original health insurers and successor health insurers shall comply with the Prior Authorization Fairness Act, compiled in part 36 of this chapter.

SECTION 3. Tennessee Code Annotated, Section 56-7-1013(h), is amended by adding the following new subdivision (6):

(6) The Prior Authorization Fairness Act, compiled in part 36 of this chapter.

SECTION 4. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-3601. Short title.

This part is known and may be cited as the "Prior Authorization Fairness Act."

56-7-3602. Part definitions.

As used in this part:

(1) "Additional business day" means the first weekday not designated as a state or federal holiday;

(2) "Adverse determination" has the same meaning as defined in § 56-61-102;

(3) "Chronic condition" means a condition that has an expected duration of one (1) year or more and requires ongoing medical attention or limits activities of daily living, or both;

(4) "Commissioner" has the same meaning as defined in § 56-1-102;

(5) "Emergency healthcare services" means emergency services as defined in § 56-7-2355;

(6) "Enrollee" has the same meaning as defined in § 56-6-703;

(7) "Enrollee benefit plan" means the right to have a payment made by a health carrier for a prescription drug listed on the applicable formulary or healthcare services in accordance with coverage contained within a health benefit plan delivered, issued for delivery, or renewed in this state;

(8) "Facility" means an institution licensed under title 33 or 68;

(9) "Health carrier" has the same meaning as defined in § 56-61-102;

(10) "Healthcare prescriber" means a prescriber as defined in § 53-10-203;

(11) "Healthcare professional" has the same meaning as defined in § 56-61-102;

(12) "Healthcare provider" has the same meaning as defined in § 56-61-102;

(13) "Healthcare service" means a service rendered by a healthcare provider or at a practice that provides testing, monitoring, diagnosis, or treatment of a human disease or condition, or dispenses medical devices, medical appliances, or medical goods for the treatment of a human disease or condition;

(14) "Inpatient service" means care provided in a hospital or other type of inpatient facility where an individual is admitted and spends one (1) or more nights, depending on the individual's medical condition;

(15) "Medically necessary" or "medical necessity" has the same meaning as defined in § 56-61-102;

(16) "Physician" means a medical doctor or osteopathic physician with a valid state medical license issued pursuant to title 63, chapter 6 or 9;

(17) "Practice" means an entity formed with at least one (1) healthcare provider to provide healthcare services;

(18) "Prescription drug" has the same meaning as defined in § 56-7-3201;

(19) "Prior authorization" means a written or oral determination made by a health carrier or utilization review organization, or an agent of such carrier or organization, that an enrollee's receipt of a healthcare service is a covered benefit under the applicable plan and that a requirement of medical necessity or other requirements imposed by such utilization review organization as prerequisites for payment for such services have been satisfied;

(20) "Urgent care request" has the same meaning as defined in § 56-61-102; and

(21) "Utilization review organization" means:

(A) A health carrier or other entity, including a designee of such carrier or entity, that reviews or issues prior authorizations for a health carrier; and

(B) A health maintenance organization, or another individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, behavioral health, prescription drug, or other health benefits to a person treated by a healthcare provider in this state under a health insurance policy, plan, or contract.

56-7-3603. Requirements for initial adverse determinations.

(a) If a utilization review organization makes an adverse determination for a prior authorization of a healthcare service, then the carrier or organization shall include the following in the notification to the enrollee and the enrollee's healthcare provider requesting the prior authorization on the enrollee's behalf:

(1) The reasons for the adverse determination and, if applicable, related evidence-based criteria, including a description of missing or insufficient documentation or lack of coverage of the enrollee for the healthcare service;

(2) The right to appeal the adverse determination;

(3) Instructions on how to file the appeal; and

(4) Additional documentation necessary to support the appeal.

(b) An adverse determination regarding a request for prior authorization for a healthcare service must be made by a licensed physician or a healthcare professional with the same or a similar specialty as the healthcare professional requesting the prior authorization.

(c) This section does not apply to an initial adverse determination for prescription drugs that are covered under an enrollee's benefit plan.

56-7-3604. Appeals of an electronic and non-electronic initial adverse determination.

(a)

(1) For prior authorization adverse determination appeals submitted electronically, a utilization review organization shall ensure that such appeals are reviewed or made by a licensed physician or healthcare professional with the same or a similar specialty as the healthcare professional who requested the initial prior authorization. The reviewing healthcare professional shall:

(A) Possess a current and valid non-restricted license to practice in this state or another state or territory of the United States;

(B) Be knowledgeable of, and have experience providing, the healthcare services under appeal;

(C) Not have been directly involved in making the adverse determination; and

(D) Consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical records provided by the enrollee's healthcare provider, and any medical literature provided.

(2) Utilization review organizations shall perform:

(A) A non-urgent prior authorization review within seven (7) calendar days; and

(B) An urgent care prior authorization review within seventy-two (72) hours, plus, if applicable, one (1) additional business day.

(3) A health carrier or utilization review organization, or a healthcare professional on its behalf, shall not receive compensation as an incentive for issuing an adverse decision.

(b)

(1) Utilization review organizations shall review all prior authorization adverse determination appeals that are not submitted electronically in accordance with standards set by the National Committee on Quality Assurance.

(2) For purposes of this part, prior authorization appeals submitted via facsimile are not submitted electronically.

56-7-3605. Prior authorization submissions.

(a) A prior authorization request under this section that has not been submitted as an urgent care request by the healthcare provider is deemed approved within seven (7) calendar days, or after the date and time of submission if the health carrier or utilization review organization, or its designee:

(1) Fails to approve or deny the request;

(2) Fails to request from the healthcare provider all additional information needed to make a decision; or

(3) Except for a prior authorization for a prescription drug, fails to notify the healthcare provider that prior authorization is being questioned for medical necessity.

(b) The utilization review organization has an additional five (5) calendar days to process the prior authorization once the healthcare provider submits the requested additional information.

(c) Except as provided in subsection (e), the prior authorization request process must not exceed seventeen (17) calendar days. Failure by a healthcare provider to submit the required documentation within seventeen (17) days necessitates the provider requesting a new prior authorization.

(d) If notice is provided pursuant to subdivision (a)(3), then the notice must include the following:

(1) A direct phone number to the utilization review organization;

(2) Hours of business operation of the utilization review organization's physician with decision-making authority to review the prior authorization; and

(3) A statement that there is an opportunity to discuss the medical necessity of the healthcare service directly with the healthcare professional who will be responsible for approving or denying the prior authorization of the healthcare service under review.

(e) If a notice complies with subdivision (d), then the prior authorization request process must not exceed seventeen (17) days. Failure by a healthcare provider to submit the required documentation within seventeen (17) days necessitates the provider requesting a new prior authorization.

(f) A prior authorization request under this section that has been submitted as an urgent care request by the healthcare provider is deemed approved by the utilization review organization if the utilization review organization fails to approve or deny the request, or request all additional information needed to make a decision within seventy-two (72) hours plus, if applicable, one (1) additional business day, after the date and time of submission of the prior authorization request. The healthcare provider shall submit requested additional information within seventy-two (72) hours, plus, if applicable, one (1) additional business day, of receiving a request for additional information. If additional information is requested, then the prior authorization request is deemed approved by the health carrier or utilization review organization if it fails to grant the request, deny the request, or otherwise respond to the request of the healthcare provider within seventy-two (72) hours, plus, if applicable, one (1) additional business day, after the date and time of the submission for all requested additional information. Failure by a provider to submit the required documentation within seventy-two (72) hours, plus, if

applicable, one (1) additional business day, necessitates the healthcare provider requesting a new prior authorization.

(g) A health carrier that provides coverage for emergency services in an emergency department of a hospital or freestanding emergency room facility shall comply with § 56-7-2355 and shall not require a prior authorization for such emergency services.

(h) A healthcare professional must submit a request for a prior authorization at least five (5) calendar days prior to the provision of the service or therapy for non-urgent prior authorizations.

(i) This section applies only to electronic submissions, unless the utilization review organization or health carrier does not allow electronic submission of prior authorizations.

(j) For the purposes of this section, health carriers are not required to provide the notice in accordance with § 56-7-3603 in writing.

56-7-3606. Chronic conditions.

(a) If a prior authorization is required for a healthcare service for the treatment of a chronic condition of an enrollee, then the prior authorization remains valid for at least six (6) months, from the date the healthcare professional or provider receives the prior authorization approval, unless the clinical criteria as specified in § 56-7-3607 state otherwise.

(b) If prior authorization is required for a prescription drug for the treatment of a chronic condition of an enrollee, then the prior authorization remains valid for at least six (6) months from the date the healthcare professional or provider receives the prior authorization approval, unless the clinical criteria as specified in § 56-7-3607 state otherwise.

(c) This section does not apply to the requirements of a prior authorization for the prescription of a schedule II, III, IV, or V drug. However, notice must be given to the healthcare provider pursuant to this section if prior authorization is or may be required for a schedule II, III, IV or V drug.

(d) This section does not require a policy of health insurance coverage to cover care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

(e) This section does not apply to inpatient services.

56-7-3607. Clinical criteria.

(a) A health carrier shall maintain a complete list of healthcare services for which a prior authorization is required.

(b) The clinical review criteria for healthcare services or prescription drugs requiring prior authorization must:

(1) Be based on nationally recognized, generally accepted standards for national, clinical criteria, except where state law provides its own standard;

(2) Not be arbitrary and must be cited by the utilization review organization;

(3) Be developed in accordance with the current standards of a national medical accreditation entity;

(4) Ensure quality of care and access to needed healthcare services;

(5) Be evidence-based;

(6) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(7) Be evaluated and updated in accordance with § 56-7-3618.

(c) A claim for failure to obtain prior authorization must not be denied if the prior authorization requirement was not in effect on the date of service on the claim.

56-7-3608. Electronic prior authorization.

(a) A health carrier or utilization review organization shall accept and respond electronically to prior authorization requests from a healthcare provider submitted through a secure electronic transmission as determined by the carrier or organization.

(b) If a prior authorization for a prescription drug is submitted electronically using the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard for electronic prior authorization (ePA) transactions, then the health carrier or utilization review organization must accept and respond to the prior authorization request using the NCPDP SCRIPT Standard for ePA transactions.

(c) This section does not require a healthcare professional to submit prior authorization requests electronically.

56-7-3609. Expiration date for a prior authorization.

Except as provided in § 56-7-3606, a prior authorization for an enrollee for a healthcare service is valid for at least six (6) months from the date the prior authorization is approved.

56-7-3610. Prior authorization and opioid use disorder.

(a) A utilization review organization and health carrier shall not require prior authorization for prescription drugs labeled by the United States food and drug administration for the treatment of opioid use disorder.

(b) This section does not require a policy to cover any care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary unless otherwise required by law.

(c) This section does not apply to behavioral health inpatient services.

56-7-3611. Medical necessity.

The medical necessity or appropriateness of emergency healthcare services must comply with the Consolidated Appropriations Act of 2021 (Pub. L. 116-260). Restrictions on coverage of emergency healthcare services provided by nonparticipating providers must not be greater than restrictions that apply when participating providers provide those services.

56-7-3612. Changing prior authorization requirements.

(a) A utilization review organization shall provide notice to healthcare providers in its network of each new prior authorization requirement, or restriction or amendment to an existing prior authorization requirement, at least sixty (60) days prior to the effective date of the change.

(b) A utilization review organization shall provide notice to healthcare providers in its network of each new prior authorization requirement, or restriction or amendment to an existing prior authorization requirement, for a prescription drug at least forty-five (45) days prior to the effective date of the change unless any of the following apply:

(1) The United States food and drug administration has:

(A) Issued a statement that calls into question the clinical safety of the drug;

(B) Required the manufacturers to conduct post-market safety studies and clinical trials after the approval of the drug;

(C) Issued any drug safety-related labeling changes; or

(D) Required the manufacturers to implement special risk management programs;

(2) The drug receives a new approval from the United States food and drug administration and has become available; or

(3) The United States food and drug administration has approved expanded use of the drug.

(c) Notice required by this section must be distributed through:

(1) The utilization review organization's website or the healthcare provider's portal; and

(2) Written communication sent to a dedicated email address and regular mailing address for the healthcare provider or as stipulated in the contract between the healthcare provider and the utilization review organization. The healthcare provider may be required to submit a dedicated email address and regular mailing address to receive the notices required by this subsection (c).

56-7-3613. Payment.

(a) A health carrier or utilization review organization shall pay a healthcare provider at the contracted payment rate for a healthcare service provided by the healthcare provider per an approved prior authorization unless:

(1) The healthcare provider knowingly and materially misrepresented the healthcare service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the health carrier;

(2) The healthcare provider was no longer contracted with the patient's health benefit plan on the date the healthcare service was provided;

(3) The healthcare provider failed to meet the timely filing requirements of the health carrier; or

(4) The health carrier does not have liability for a claim.

(b) A health carrier shall pay a healthcare provider for performing a healthcare service if the prior authorization for the service was obtained by another healthcare provider.

(c) The health carrier shall provide reimbursement for healthcare services retroactively deemed medically necessary, regardless of when prior authorization was approved, for a maximum period of eighteen (18) months.

(d) Payment must be guaranteed when a prior authorization submitted under § 56-7-3605 is approved.

(e) This section does not apply to prescription drugs that are covered under an enrollee's benefit plan.

56-7-3614. Prior authorization transfers.

(a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's healthcare provider, a prior authorization granted to an enrollee from a previous utilization review organization or health carrier must be honored

for at least the initial ninety (90) days of an enrollee's coverage under a new health benefit plan.

(b) During the time period described under subsection (a), a health carrier or utilization review organization may perform its own review to approve or deny the prior authorization approved by the enrollee's previous health benefit plan effective when the initial ninety-day period expires.

(c) If there is a change in coverage of, or approval criteria for, a previously authorized healthcare service, then the change in coverage or approval criteria must not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's health benefit plan year.

(d) A health carrier or utilization review organization shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes plans carried or administered by the same health carrier.

56-7-3615. Related service.

(a) A utilization review organization shall not deem as incidental or deny claims for supplies or healthcare services that are routinely used as part of a healthcare service when:

(1) A closely related service has received prior authorization; or

(2) Prior authorization for the healthcare service is not required.

(b) As used in this section, "closely related service" means a similar service to the service allowed by prior authorization and required by the standard of care.

56-7-3616. Reviewer criteria.

(a) A health carrier is responsible for monitoring all utilization review activities performed on its behalf and for ensuring that all requirements of this chapter and applicable rules are met.

(b) The health carrier shall ensure that appropriate personnel have operational responsibility for the conduct of the utilization review program.

(c) Whenever a health carrier contracts with a utilization review organization to perform services subject to this part or applicable rules, the commissioner shall hold the health carrier responsible for monitoring the activities of such utilization review organization and for ensuring that the requirements of this part and applicable rules are met.

(d) A utilization review organization shall use clinical criteria as specified in § 56-7-3607(b).

56-7-3617. Statistics.

A health carrier or utilization review organization requiring prior authorization shall make de-identified aggregate statistics available by service code regarding prior authorization approvals and denials on its website in a readily accessible format. The commissioner shall determine the information required in order to comply with this section and in accordance with applicable state and federal privacy laws. Such statistics include, but are not limited to:

(1) The number of initial prior authorization requests that were approved or denied during the previous benefit plan year by the health carrier or utilization review organization;

(2) The number of prior authorization requests that were appealed;

(3) The number of appeals overturned and the number granted;

(4) The time between submission of an initial prior authorization request and response;

(5) The top five (5) reasons for denial;

(6) The average time between submission and response for an initial prior authorization request;

(7) The average time between submission and response for an appeal of a prior authorization denial; and

(8) Any other information that the commissioner determines appropriate.

56-7-3618. Prior authorization requirements.

A health carrier or utilization review organization shall, at least annually, review its prior authorization requirements and consider removal of prior authorization where a prescription or medical service check is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications.

56-7-3619. Website notice requirements.

(a) A health carrier or utilization review organization shall make all current prior authorization requirements readily accessible on its website to healthcare providers.

(b) The website must indicate each service subject to prior authorization while satisfying the following requirements:

(1) Putting the lettering and notification for each service in bold typeface;

(2) Indicating when prior authorization became required for policies issued or delivered in this state, including the termination date or dates, if applicable;

(3) Identifying the date when the Tennessee-specific requirement was listed on the health carrier's or its contracted review utilization review organization's website;

(4) Providing the date, the prior authorization requirement was removed from the Tennessee-issued policy, if applicable; and

(5) Providing access to a standardized electronic prior authorization request transaction process, if applicable.

56-7-3620. Applicability.

(a) Except as provided in subsection (b), this part applies to all:

(1) Insurers providing a healthcare plan that pays for the provision of healthcare services to covered persons; and

(2) Healthcare plans and state healthcare plans.

(b) This part does not apply to:

(1) Healthcare plans that are subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.);

(2) A policy of insurance issued pursuant to a contract with the bureau of TennCare;

(3) TennCare or a successor program provided for in title 71, chapter 5; or

(4) CoverKids or a successor program provided for in the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11.

56-7-3621. Provider notification to health carrier.

If a health carrier requires a healthcare provider to notify the health carrier that an enrollee has received a healthcare service or has been admitted to a facility, such notification requirement includes, if applicable, one (1) additional business day if the notification deadline falls on a weekend or state or federal holiday.

56-7-3622. Rules.

The commissioner may promulgate rules to carry out this part in accordance with the Uniform Administrative Procedures Act, codified in title 4, chapter 5.

SECTION 5. If a provision of this act, or its application to a person or circumstance is held invalid, then the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are severable.

SECTION 6. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 7. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2025, unless otherwise specified in this act, the public welfare requiring it.

HOUSE BILL NO. 885

PASSED: April 18, 2023

CAMERON SEXTON, SPEAKER
HOUSE OF REPRESENTATIVES

RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 11th day of May 2023

BILL LEE, GOVERNOR