B25-124 Section by section analysis

- Section 2 – Definitions
    - Adverse determination – decision made by review entity to deny coverage because it is not medically necessary or experimental drug
    - Emergency health care services – service provided in am emergency facility for a condition a reasonable person would know could put a person in serious health jeopardy
    - Enrollee – individual eligible to receive insurance benefits
    - Medication assisted treatment – medicine + counselling = comprehensive SUD treatment
    - Prior authorization – how a "utilization review entity" (see below) determines the medical necessity of covered healthcare services, AND the requirement an enrollee or provider notify an insurer/utilization review entity prior to providing a requested service.
    - Urgent health care service – service that a physician deems necessary and expedited to prevent life threatening conditions or severe pain (higher threshold than emergency) OR Medication Assisted Treatment
    - Utilization review entity **(URE)** – an entity doing prior auths for:
        - An employer with employees in DC
        - An insurer that writes insurance policies
        - PPO or HMO
        - An entity or person offering a health benefit to a person treated by a DC located provider
- Section 3 – Prior authorization requirements and restrictions
    - URE must make prior auth requirements known through
        - Website accessible to everyone
        - Email
        - Phone call
    - Requirements must be easy to understand, include all drugs requiring a PA, and include if applicable clinical guidelines for requiring a PA
    - No changes to prior auth requirements can become official until the website updates are made to reflect the change
- Section 4 – Prior authorization determinations
    - When a prior auth is granted or denied, notification must be made within 24 hours of the determination.
    - Adverse determinations must include grounds for denial and appeals information
    - Prior auth considerations from the previous five years must be made available on the insurer's website
- Section 5 – Length of prior auth
    - Prior auths shall be valid for one year regardless of dosage changes within the law
    - EXCEPTION – if the prior auth is for a long-term or chronic condition, the prior auth is valid for the length of the treatment
- Section 6 – Personnel qualified to make adverse determinations

    - Adverse determinations must be made by a physicians licensed in DC and of the same specialty who would normally manage the condition being considered. The medical director of the URE (who also must be DC licensed) oversees all adverse determinations
- Section 7 – Consultation prior to an adverse determination
    - A URE must tell a provider their decision is being reviewed. If an adverse decision is made, the provider must have access to a telephone consult with the physician making the adverse determination (see above).
- Section 8 – Appeals
    - An enrollee is allowed to appeal an adverse determination
    - Appeals can be submitted via website or paper
    - 24 hour window to share determination of an appeal and URE must provide name of physician doing review as well as medical grounds for determination
- Section 9 – Personnel qualified to review appeals
    - Only physicians can review appeals
        - That physician must be DC licensed, be in the same type of specialty that treats condition in question for at least 5 years, be knowledgeable of the treatment in question, and not be employed by the URE except via arrangement to handle appeals, and was not involved in original decision
    - Reviews are based on medical facts of the case
- Section 10 – Utilization review entities' obligations with respect to prior authorizations in non-urgent, urgent, and emergency situations
    - A URE must make a determination on a prior auth once the needed materials are obtained within 3 days, otherwise it is automatically approved.
    - Urgent care services reduce this window to 24 hours
    - Prior auths are prohibited for pre-hospital transport or emergency health care services (see above). The enrollee/provider has a 24 hour grace period before needing to notify an insurer of the emergency services
    - Determining appropriateness of services cannot be based on in-network status of provider
- Section 11 - Prior authorization limitations
    - Prior auth based solely on cost is prohibited
    - Prior auth is only required for experimental treatments or "determination of medical necessity for different care".
    - Prior auth cannot be required for MAT for OUD treatment
- Section 12 – Retrospective denial
    - Not allowed if care is provided within 45 days of prior auth being received
- Section 13 – Continuity of care for enrollees
    - When an enrollee changes insurance, the prior auths from previous insurer must be honored for 60 days as long as documentation is provided
    - Change in coverage will not impact prior auth status
- Section 14 – Health care services deemed authorized if a utilization review entity fails to comply with the requirements of this Act
- If a URE/insurer doesn't comply with requirements, the prior auth in question is deemed approvedSection 15 – Data collection

    - Entities requiring prior auths must make data publicly available on their website, including compliance with this law's requirements
- Section 16 – Uniform Health Insurance Claim Forms Act changes
    - URE must use an NCPDP SCRIPT Standard ePA transaction based system to issue prior auths.
    - Secure transmissions must be integrated with a physician's HER to be considered legal transmissions
- Section 17 – HIPAA Conformity Act and No Fault Motor Vehicle Insurance Act amendments
    - If an employer has a negotiated health care plan, they are required to notify participants of the difference in coverage between their plan and the standard plan
- Section 18 – FIS
    - No fiscal impact
- Section 19 – Effective date
    - The effective date is once the bill goes through the District and Congressional approval process and is published in the DC Register.