SB0275S01 compared with SB0275

~~{deleted text}~~ shows text that was in SB0275 but was deleted in SB0275S01.

inserted text shows text that was not in SB0275 but was inserted into SB0275S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Steve Eliason proposes the following substitute bill:

MEDICAL PREAUTHORIZATION AMENDMENTS

2024 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Jen Plumb

House Sponsor: ~~{_____}~~Robert M. Spendlove

LONG TITLE

General Description:

This bill enacts provisions related to authorization requests.

Highlighted Provisions:

This bill:

- defines terms;
- creates deadlines for when a managed care organization must respond to certain authorization requests~~{; and}~~.

~~{~~- ~~creates a reporting requirement.~~

~~}~~**Money Appropriated in this Bill:**

None

Other Special Clauses:

~~{None}~~ This bill provides a special effective date.

Utah Code Sections Affected:

ENACTS:

31A-45-404, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-45-404** is enacted to read:

31A-45-404. Timeliness of decisions for preauthorization.

(1) As used in this section:

(a) "Adverse preauthorization determination" means the same as that term is defined in Section 31A-22-650.

(b) "Concurrent request" means a request for medical care while the member is in process of receiving requested medical care or services.

(c) "Determination" means a determination by a managed care organization, pharmacy benefit manager, or the managed care organization's designee that, based on the member's benefits and plan's policies, a requested service or medication is approved, denied, or reduced.

(d) "Nonurgent request" means a request for medical care, medication, or services where a delay of more than 10 days would not jeopardize an individual's health.

(e) "Post-acute services" means services and medical care provided to an individual after discharge from a general acute care hospital including:

(i) inpatient rehabilitation;

(ii) skilled nursing facility services;

(iii) home health;

(iv) palliative care;

(v) hospice; or

(vi) medications required for safe transition of care.

(f) "Post-service request" means a request for medical care or services after the care or services have been provided.

(g) "Preservice request" means a request for medical care or services prior to an individual receiving the requested care or services.

(2) For the following requests from a health care provider for medical care or services on behalf of a member of a managed care organization, the managed care organization shall

respond within:

(a) for a concurrent request, including for post-acute services:

(i) 24 hours from the hour the request is transmitted; or

(ii) if the managed care organization requests additional information under Subsection ({~~6~~}5), 24 hours from the hour the managed care organization receives the additional information; or

(b) for a preservice request that is urgent:

(i) 48 hours from the hour the request is transmitted; or

(ii) if the managed care organization requests additional information under Subsection ({~~6~~}5), 24 hours from the hour the managed care organization received the additional information;

(c) for a preservice request that is not urgent, 10 days from the day the request was transmitted; and

(d) for a post-service care request, 30 days from the day the request was transmitted.

(3) A managed care organization shall complete an appeal from an adverse preauthorization determination in the same amount of time as the time for the applicable request described in Subsection (2).

(4) A managed care organization may not deny a post-service request solely because the request for service was initiated after the service was performed.

~~{ (5) A managed care organization shall report annually to the department the following:~~

~~(a) percentage of post acute determinations completed within the timelines described in this section;~~

~~(b) percentage of post acute requests where additional information is requested;~~

~~(c) the total number of post acute initial requests that were approved and denied, including the percentage; and~~

~~(d) the total number of post acute appeals that were approved or denied, including the percentage.~~

~~}~~ ({~~6~~}5) (a) A managed care organization may request additional information for an authorization request described in this section.

(b) For a request described in Subsection (2)(a) or (b), the managed care organization shall submit a request for more information no later than 24 hours after the hour the request is

transmitted to the managed care organization.

({7}6) If a managed care organization fails to respond to a request described in Subsection (2) within the time specified, or to request information in accordance with Subsection ({6}5)(b) within the time specified, the request is deemed to be approved.

({8}7) This section only applies to requests from a tertiary hospital or a quaternary hospital.

(8) This section does not apply to:

(a) the Public Employees' Benefit and Insurance Program; or

(b) claims filed as part of the Medicaid program.

Section 2. **Effective date.**

This bill takes effect on {May}January 1, {2024}2025.