**Prior Authorization and Utilization Management Side-by-Side**

**Infographic simplified principles** (from [AHIP agreed-upon principles](https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf))**:**

* PAs should be rare: Payers agreed to use PAs based on “stratification of performance” and evidence-based medicine
* Criteria should be clear: Payers agreed to make PA requirements, criteria and rationale transparent and easily accessible
* Protect Patients: Payers have agreed to protect care during active courses of treatment

*Note: California legislation column does not reflect current Prior Authorization rules found in §1367.01 of the Health and Safety Code, and §10123.135 of the Insurance Code.*

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| Issue | PPS Draft UM Principles | AMA Consensus Standard (APTA Supports) | [California legislation](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB931) - vetoed | Nebraska legislation | Georgia law | [Maine statute](https://fastdemocracy.com/bill-search/me/131/bills/MEB00012186/)  [– signed into law 6/23/2023](https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0548&item=4&snum=131) |
| PT-Specific Considerations | PPS1: Prior authorization shall not be required for the first 12 physical therapy (PT) visits with no duration of care limitation. The first authorization for PT care may only occur for visits after 12 visits. (based on FOTO data) |  | 10123.75. (a). A health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy shall not, for a new episode of care, require prior authorization for the initial 12 treatment visits for physical therapy.  (b) For purposes of this section, “new episode of care” means treatment for a new or recurring condition for which the insured has not been treated by the provider within the previous 90 days and is not currently undergoing active treatment.  Mirrored section would be added to Health and Safety Code (add Section 1367.26) | Initial twelve treatment sessions of new episodes of care shall not require prior authorization by a managed care organization for Chiropractic Services, Physical Therapy, Occupation Therapy and Speech Language Pathology. |  | 24-A MRSA §4304-A, sec. 1. prohibition of prior authorizations prior to 12 visits for new episodes of care for occupational or physical therapy. New episode of care means treatment for a recurring  condition for which an enrollee has not been treated within the previous 90 days. |
|  | PPS2: Prior authorization shall not be permitted for any PT care provided to chronic pain patients for the first 90 days post-diagnosis, in order to provide the necessary non-pharmacologic management of pain through physical therapy. (CO) |  |  |  |  |  |
| Clinical Validity | PPS8: UR/UM Organizations shall not use claims data as “evidence of outcomes” to develop their algorithms and /approval policy. | Principle #1:  Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public. |  | a managed care organization that implements an automated prior authorization system shall use evidence-based clinical guidelines  …  decision to deny or modify requests for authorization (shall be) based on medical necessity, not just to ratify an automated response that would result in the denial or modification of the authorization request. | 33-46-4 (6) 'Clinical criteria' means the written policies, decisions, rules, medical protocols, or guidelines used by a private review agent or utilization review entity to determine medical necessity.  *And also*  33-46-4 (15) 'Medical necessity' or 'medically necessary' means healthcare services that a prudent physician or other healthcare provider would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a manner that is:  (A) In accordance with generally accepted standards of medical or other healthcare practice;  (B) Clinically appropriate in terms of type, frequency, extent, site, and duration;  (C) Not primarily for the economic benefit of the health insurer or for the convenience of the patient, treating physician, or other healthcare provider; and  (D) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan. |  |
|  |  |  |  |  | 33-46-6 (a)(1) … The medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review or utilization review program shall be established with input from health care healthcare providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency or utilization review entity and documentation of such protocols shall be made available upon request of health care healthcare providers; or, where not so addressed, protocols, including reconsideration and appeal processes as well as other relevant health care healthcare issues used in the private review such program, shall be established based on input from persons who are licensed in the appropriate health care healthcare provider's specialty recognized by a licensure agency of such a health care healthcare provider; |  |
|  |  | Principle #2: Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials. |  |  | (9) Private review agents and utilization review entities shall develop applicable utilization review plans and conduct utilization review in accordance with standards as set forth under this chapter and rules and regulations adopted by the Commissioner.  (b) The Commissioner may consider nationally recognized accreditation standards for utilization review and may adopt by rule or regulation any such standards for the purposes of enforcing this chapter, to the extent such standards do not conflict with this chapter.  (c) The Commissioner may maintain on the department website a list of nationally recognized accreditation entities. |  |
|  | PPS3: A surgeon’s post-op protocol for physical therapy for a certain period of time shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon’s protocol is not medically necessary. |  |  | For purposes of this section prior authorization is a decision *made by a managed care organization* that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.  [emphasis added] |  |  |
|  | PPS9: All UR/UM organizations shall staff peer-to-peer reviews with credentialed and state-licensed clinicians for the type of service being reviewed. | Principle #3: Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues. |  | A managed care organization that implements an automated prior authorization system shall ensure that a licensed physician or licensed health care professional who is competent to evaluate the specific clinical issues involved in the health service | 33-46-4 (7) 'Clinical peer' means a healthcare provider who is licensed without restriction or otherwise legally authorized and currently in active practice in the same or similar specialty as that of the treating provider, and who typically manages the medical condition or disease at issue and has knowledge of and experience providing the healthcare service or treatment under review. |  |
| Continuity of Care |  | Principle #4: Utilization review entities should offer a minimum of a 60-day grace period for any step-therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed. |  |  |  |  |
|  |  | Principle #5: A drug or medical service that is removed from a plan’s formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year. |  |  |  |  |
|  |  | Principle #6: A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment. |  |  |  |  |
|  |  | Principle #7: No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy. |  |  |  |  |
| Transparency and Fairness | PPS7: All UR/UM organizations shall provide all medical evidence-based policy information that accompanies accompanying algorithms used to manage care upon request by any licensed provider. | Principle #8: Utilization review entities should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request. |  | system and algorithms used, including research citations and references of the most recent revisions to date, are made available for download on the managed care organization’s provider internet website. |  |  |
|  |  | Principle #9: Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing. |  |  |  |  |
|  |  | Principle #10: Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publicly available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:   i. Health care provider type/specialty;  ii. Medication, diagnostic test or   procedure;  iii. Indication;  iv. Total annual prior authorization  requests, approvals and denials;  v. Reasons for denial such as, but not  limited to, medical necessity or   incomplete prior authorization  submission; and  vi. Denials overturned upon appeal.  These data should inform efforts to refine and improve utilization management programs. |  |  |  |  |
|  | PPS6: Any denial or reduction in services must shall reference applicable payer policy, and also include an explanation for the denial, and must be produced to both the provider and the patient. | Principle #11: Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. |  |  | 33-46-4 (18) 'Prior authorization' means any written or oral determination made at any time by a claim administrator or an insurer, or any agent thereof, that a covered person's receipt of healthcare services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as |  |
|  |  |  |  |  | 33-46-27.  A private review agent or utilization review entity shall render a prior authorization or adverse determination concerning urgent healthcare services and notify such person's healthcare provider, or such provider's appropriately qualified designee, of that prior authorization or adverse determination no later than 72 hours after receiving all information  needed to complete the review of the requested healthcare services. |  |
|  |  |  |  |  | 33-46-26. Effective January 1, 2022, until December 31, 2022, if an insurer requires prior authorization of a healthcare service, a private review agent or utilization review entity  shall notify the covered person's healthcare provider, or such provider's appropriately  qualified designee, of any prior authorization or adverse determination within 15 calendar  days of obtaining all necessary information to make such authorization or adverse determination. Effective January 1, 2023, if an insurer requires prior authorization of a  healthcare service, a private review agent or utilization review entity shall notify the covered person's healthcare provider, or such provider's appropriately qualified designee, of any prior authorization or adverse determination within 7 calendar days of obtaining all necessary information to make such authorization or adverse determination. |  |
|  |  | All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan’s covered alternative treatment and detail the provider’s appeal rights. |  |  | 33-46-22 A private review agent or utilization review entity shall ensure that all appeals are reviewed by an appropriate healthcare provider who shall:  (1) Possess a current and valid nonrestricted license or maintain other appropriate legal authorization;  (2) Be currently in active practice in the same or similar specialty and who  typically manages the medical condition or disease;  (3) Be knowledgeable of, and have experience providing, the healthcare service under appeal;  (4) Not have been directly involved in making the adverse determination; and  (5) Consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical or other records provided to the  private review agent or utilization review entity by the covered person's healthcare provider, any relevant records provided to such agent or entity by a facility, and any medical or other literature provided to such agent or entity by the healthcare provider. |  |
|  |  |  |  |  | 33-46-8(b)(4)(B) (certificate may only be granted to an organization that):  Maintains records of such written complaints for five years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require; |  |
| Timely Access and Admin. Efficiency | PPS10: Providers shall be compensated with for each hour of data entry of clinical information required for the UR/UM authorization. a Such compensation shall equal 50% of CPT of the top PT CPT code 97110 per the fee schedule payment for each hour of data entry of clinical information required for the UR/UM authorization. Providers will shall invoice the UR/UM organization on a monthly basis OR Payers shall increase fee schedules commensurate with increased administrative expenses. |  |  |  |  |  |
|  |  | Principle #12: A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions. |  |  |  |  |
|  |  | Principle #13: Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim. |  |  |  |  |
|  |  | Principle #14: In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received. |  |  |  |  |
|  |  | Principle #15: If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information. |  |  | 33-46-4 (21) 'Urgent healthcare service' means a healthcare service with respect to which the application of the time periods for making a nonexpedited prior authorization, which, in the opinion of a physician or other healthcare provider with knowledge of the covered person's medical condition:  (A) Could seriously jeopardize the life or health of the covered person or the ability of such person to regain maximum function; or  (B) Could subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. Such term shall include services provided for the treatment of substance use disorders  which otherwise qualify as an urgent healthcare service. |  |
|  |  |  |  |  | 33-46-29. Each violation by a private review agent or utilization review entity of deadline or other requirements specified in this chapter shall result in the automatic authorization of healthcare services under review by such private review agent or utilization review entity  if such noncompliance is related to such services. Notwithstanding the foregoing, noncompliance based on a de minimis violation that does not cause, or is not likely to cause, prejudice or harm to the covered person shall not result in the automatic authorization of such healthcare services, so long as the insurer demonstrates that the violation occurred due to good cause or due to matters beyond the control of the insurer and that such violation occurred in the context of an ongoing good faith exchange of information between the insurer and the covered person, or, if applicable, the covered  person's healthcare provider or authorized representative. |  |
|  |  | Principle #16: Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination. |  |  |  |  |
|  | PPS4: Prior authorization shall not be permitted for unanticipated emergency healthcare services, urgent healthcare services, or covered healthcare services which are incidental to the primary covered healthcare service (such as surgery,) and determined by the covered person's physician to be medically necessary. (GA) | Principle #17: Prior authorization should never be required for emergency care. |  |  | 33-46-24. Prior authorization shall not be required for unanticipated emergency healthcare services, urgent healthcare services, or covered healthcare services which are incidental to the primary covered healthcare service and determined by the covered person's physician or dentist to be medically necessary.  33-46-25. An insurer cannot require prior authorization for emergency prehospital ambulance transportation or for the provision of emergency healthcare services.  33-46-4. (9) 'Emergency healthcare services' means healthcare services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:  (A) Placing the patient's health in serious jeopardy;  (B) Serious impairment to bodily functions; or  (C) Serious dysfunction of any bodily organ or part. |  |
|  |  |  |  |  | 33-46-4. (a)(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating health care healthcare provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented; |  |
|  |  |  |  |  | 33-46-4 (21) 'Urgent healthcare service' means a healthcare service with respect to which the application of the time periods for making a nonexpedited prior authorization, which, in the opinion of a physician or other healthcare provider with knowledge of the covered person's medical condition:  (A) Could seriously jeopardize the life or health of the covered person or the ability of such person to regain maximum function; or  (B) Could subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. Such term shall include services provided for the treatment of substance use disorders which otherwise qualify as an urgent healthcare service. |  |
|  |  |  |  |  | 33-46-4 (a)(4) In cases where a private review agent or utilization review entity is responsible for utilization review for a payor an insurer or claim administrator, the utilization review such agent or entity should respond promptly and efficiently in accordance with this chapter to all requests including concurrent review in a timely method, and a method for an expedited authorization process shall be available in the interest of efficient patient care;  33-46-4 (a) (5) In any instances where the private review agent or utilization review agent entity is questioning the medical necessity or appropriateness of care, the attending treating health care provider, or such provider's appropriately qualified designee, shall be able to discuss the plan of treatment with an identified health care provider a clinical peer trained in a related specialty and no adverse determination shall be made by the private review agent or utilization review agent entity until an effort has been made to discuss the patient's care with the patient's attending treating provider, or such provider's appropriately qualified designee who shall be familiar with the patient's case, during normal working hours. In the event of an adverse determination, notice to the provider and patient will specify the reasons for the review determination. |  |
|  | PPS5: Reauthorization decisions are continued care claims which must be approved or denied within 24 hours of the request.   (limited to approval or denial) must be produced by the payer within 48 hours of the reauthorization request. (ACA) | Principle #18: Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens. |  |  |  |  |
| Alternatives and Exemptions |  | Principle #19: Health plans should restrict utilization management programs to “outlier” providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors. |  |  |  |  |
|  |  | Principle #20: Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to “gold-card” or “preferred provider” programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways. |  |  |  |  |
|  |  | Principle #21: A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan’s benefits. |  |  |  |  |
| Relationship between Payer and Utilization Review Agency |  |  |  |  | 33-46-4 (a)(7) A private review agent or utilization review entity shall not enter into any incentive payment provision contained in a contract or agreement with a payor an insurer which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings… |  |
| Certification of UR entity |  |  |  |  | 33-46-5 (a) A private review agent or utilization review entity may not conduct utilization review of health care healthcare provided in this state unless the Commissioner has granted the private review agent or utilization review entity a certificate pursuant to this chapter. No individual conducting utilization review shall require certification if such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to this Code section.  (b) The Commissioner shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the Commissioner.  (c) A certificate issued under this chapter is not transferable without the prior approval of the Commissioner. |  |
| Length of approval |  |  |  |  | 33-46-23. If initial healthcare services are performed within 45 business days of approval of prior authorization, the insurer shall not revoke, limit, condition, or restrict such authorization, unless such prior authorization is for a Schedule II controlled substance or there is a billing error, fraud, material misrepresentation, or loss of coverage. |  |