By Senator Steube

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28 protocol exception requests under certain	26	authorizations or denials to specify certain
29 circumstances; authorizing health insurers to request	28	protocol exception requests under certain
	29	circumstances; authorizing health insurers to request

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30	documentation in support of a protocol exception
31	request; providing an effective date.
32	
33	Be It Enacted by the Legislature of the State of Florida:
34	
35	Section 1. Section 627.42392, Florida Statutes, is amended
36	to read:
37	627.42392 Prior authorization
38	(1) As used in this section, the term:
39	(a) "Health insurer" means an authorized insurer offering
40	an individual or group insurance policy that provides major
41	medical or similar comprehensive coverage health insurance as
42	defined in s. 624.603, a managed care plan as defined in s.
43	409.962(10), or a health maintenance organization as defined in
44	s. 641.19(12).
45	(b) "Urgent care situation" has the same meaning as in s.
46	<u>627.42393.</u>
47	(2) Notwithstanding any other provision of law, effective
48	January 1, 2017, or six (6) months after the effective date of
49	the rule adopting the prior authorization form, whichever is
50	later, a health insurer, or a pharmacy benefits manager on
51	behalf of the health insurer, which does not provide an
52	electronic prior authorization process for use by its contracted
53	providers, shall only use the prior authorization form that has
54	been approved by the Financial Services Commission for granting
55	a prior authorization for a medical procedure, course of
56	treatment, or prescription drug benefit. Such form may not
57	exceed two pages in length, excluding any instructions or
58	guiding documentation, and must include all clinical
I	

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CODING: Words stricken are deletions; words underlined are additions.

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59	documentation necessary for the health insurer to make a
60	decision. At a minimum, the form must include: (1) sufficient
61	patient information to identify the member, date of birth, full
62	name, and Health Plan ID number; (2) provider name, address and
63	phone number; (3) the medical procedure, course of treatment, or
64	prescription drug benefit being requested, including the medical
65	reason therefor, and all services tried and failed; (4) any
66	laboratory documentation required; and (5) an attestation that
67	all information provided is true and accurate. The form, whether
68	in electronic or paper format, may not require information that
69	is not necessary for the determination of medical necessity of,
70	or coverage for, the requested medical procedure, course of
71	treatment, or prescription drug.
72	(3) The Financial Services Commission in consultation with
73	the Agency for Health Care Administration shall adopt by rule
74	guidelines for all prior authorization forms which ensure the
75	general uniformity of such forms.
76	(4) Electronic prior authorization approvals do not
77	preclude benefit verification or medical review by the insurer
78	under either the medical or pharmacy benefits.
79	(5) A health insurer or a pharmacy benefits manager on
80	behalf of the health insurer must provide the following
81	information in writing or in an electronic format upon request,
82	and on a publicly accessible Internet website:
83	(a) Detailed descriptions of requirements and restrictions
84	to obtain prior authorization for coverage of a medical
85	procedure, course of treatment, or prescription drug in clear,
86	easily understandable language. Clinical criteria must be
87	described in language easily understandable by a health care

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88 <u>provider.</u> 89 <u>(b) Prior authorization forms.</u> 90 <u>(6) A health insurer or a pharmacy benefits manager on</u> 91 <u>behalf of the health insurer may not implement any new</u> 92 <u>requirements or restrictions or make changes to existing</u> 93 <u>requirements or restrictions to obtain prior authorization</u> 94 <u>unless:</u> 95 <u>(a) The changes have been available on a publicly</u> 96 <u>accessible Internet website at least 60 days before the</u> 97 <u>implementation of the changes.</u> 98 (b) Policyholders and health care providers who are	2
90 (6) A health insurer or a pharmacy benefits manager on 91 behalf of the health insurer may not implement any new 92 requirements or restrictions or make changes to existing 93 requirements or restrictions to obtain prior authorization 94 unless: 95 (a) The changes have been available on a publicly 96 accessible Internet website at least 60 days before the 97 implementation of the changes.	2
91 <u>behalf of the health insurer may not implement any new</u> 92 <u>requirements or restrictions or make changes to existing</u> 93 <u>requirements or restrictions to obtain prior authorization</u> 94 <u>unless:</u> 95 <u>(a) The changes have been available on a publicly</u> 96 <u>accessible Internet website at least 60 days before the</u> 97 <u>implementation of the changes.</u>	2
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98 (b) Policyholders and health care providers who are	<u>2</u>
	<u>2</u>
99 affected by the new requirements and restrictions or changes t	
100 the requirements and restrictions are provided with a written	
101 notice of the changes at least 60 days before the changes are	
102 implemented. Such notice may be delivered electronically or by	
103 other means as agreed to by the insured or health care provide	r.
104	
105 This subsection does not apply to expansion of health care	
106 <u>services coverage.</u>	
107 (7) A health insurer or a pharmacy benefits manager on	
108 behalf of the health insurer must authorize or deny a prior	
109 authorization request and notify the patient and the patient's	
110 treating health care provider of the decision within:	
111 (a) Seventy-two hours of obtaining a completed prior	
112 <u>authorization form for nonurgent care situations.</u>	
113 (b) Twenty-four hours of obtaining a completed prior	
114 authorization form for urgent care situations.	
115 Section 2. Section 627.42393, Florida Statutes, is create	b
116 to read:	

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117	627.42393 Fail-first protocols
118	(1) As used in this section, the term:
119	(a) "Fail-first protocol" means a written protocol that
120	specifies the order in which a certain medical procedure, course
121	of treatment, or prescription drug must be used to treat an
122	insured's condition.
123	(b) "Health insurer" has the same meaning as provided in s.
124	627.42392.
125	(c) "Preceding prescription drug or medical treatment"
126	means a medical procedure, course of treatment, or prescription
127	drug that must be used pursuant to a health insurer's fail-first
128	protocol as a condition of coverage under a health insurance
129	policy or a health maintenance contract to treat an insured's
130	condition.
131	(d) "Protocol exception" means a determination by a health
132	insurer that a fail-first protocol is not medically appropriate
133	or indicated for treatment of an insured's condition and the
134	health insurer authorizes the use of another medical procedure,
135	course of treatment, or prescription drug prescribed or
136	recommended by the treating health care provider for the
137	insured's condition.
138	(e) "Urgent care situation" means an injury or condition of
139	an insured which, if medical care and treatment are not provided
140	earlier than the time generally considered by the medical
141	profession to be reasonable for a nonurgent situation, in the
142	opinion of the insured's treating physician, would:
143	1. Seriously jeopardize the insured's life, health, or
144	ability to regain maximum function; or
145	2. Subject the insured to severe pain that cannot be

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146	adequately managed.
147	(2) A health insurer must publish on its website and
148	provide to an insured in writing a procedure for an insured and
149	health care provider to request a protocol exception. The
150	procedure must include:
151	(a) A description of the manner in which an insured or
152	health care provider may request a protocol exception.
153	(b) The manner and timeframe in which the health insurer is
154	required to authorize or deny a protocol exception request or
155	respond to an appeal of a health insurer's authorization or
156	denial of a request.
157	(c) The conditions under which the protocol exception
158	request must be granted.
159	(3)(a) The health insurer must authorize or deny a protocol
160	exception request or respond to an appeal of a health insurer's
161	authorization or denial of a request within:
162	1. Seventy-two hours of obtaining a completed prior
163	authorization form for nonurgent care situations.
164	2. Twenty-four hours of obtaining a completed prior
165	authorization form for urgent care situations.
166	(b) An authorization of the request must specify the
167	approved medical procedure, course of treatment, or prescription
168	drug benefits.
169	(c) A denial of the request must include a detailed,
170	written explanation of the reason for the denial, the clinical
171	rationale that supports the denial, and the procedure to appeal
172	the health insurer's determination.
173	(4) A health insurer must grant a protocol exception
174	request if:

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175	(a) A preceding prescription drug or medical treatment is
176	contraindicated or will likely cause an adverse reaction or
177	physical or mental harm to the insured;
178	(b) A preceding prescription drug is expected to be
179	ineffective, based on the medical history of the insured and the
180	clinical evidence of the characteristics of the preceding
181	prescription drug or medical treatment;
182	(c) The insured has previously received a preceding
183	prescription drug or medical treatment that is in the same
184	pharmacologic class or has the same mechanism of action, and
185	such drug or treatment lacked efficacy or effectiveness or
186	adversely affected the insured; or
187	(d) A preceding prescription drug or medical treatment is
188	not in the best interest of the insured because the insured's
189	use of such drug or treatment is expected to:
190	1. Cause a significant barrier to the insured's adherence
191	to or compliance with the insured's plan of care;
192	2. Worsen an insured's medical condition that exists
193	simultaneously but independently with the condition under
194	treatment; or
195	3. Decrease the insured's ability to achieve or maintain
196	his or her ability to perform daily activities.
197	(5) The health insurer may request a copy of relevant
198	documentation from the insured's medical record in support of a
199	protocol exception request.
200	Section 3. This act shall take effect July 1, 2018.

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