

**First Regular Session  
Seventy-second General Assembly  
STATE OF COLORADO**

**PREAMENDED**

*This Unofficial Version Includes Committee  
Amendments Not Yet Adopted on Second Reading*

LLS NO. 19-0894.01 Christy Chase x2008

**HOUSE BILL 19-1211**

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**HOUSE SPONSORSHIP**

**Michaelson Jenet and Caraveo,**

**SENATE SPONSORSHIP**

**Williams A.,**

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**House Committees**  
Health & Insurance

**Senate Committees**

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**A BILL FOR AN ACT**

101      **CONCERNING PRIOR AUTHORIZATION REQUESTS SUBMITTED BY**  
102                    **PROVIDERS FOR A DETERMINATION OF COVERAGE OF HEALTH**  
103                    **CARE SERVICES UNDER A HEALTH BENEFIT PLAN.**

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**Bill Summary**

*(Note: <sup>gh</sup>This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://leg.colorado.gov>.)*

With regard to the prior authorization process used by carriers or private utilization review organizations (organizations) acting on behalf of carriers to review and determine whether a particular health care service prescribed by a health care provider is approved as a covered benefit under the patient's health benefit plan, the bill requires carriers

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
Capital letters or bold & italic numbers indicate new material to be added to existing statute.  
Dashes through the words indicate deletions from existing statute.

and organizations to:

- ! Publish and update their prior authorization requirements and restrictions;
- ! Comply with deadlines established in the bill for making a determination on a prior authorization request;
- ! Use current, clinically based prior authorization criteria that are aligned with other quality initiatives of the carrier or organization and with other carriers' and organizations' prior authorization criteria for the same health care service;
- ! Limit the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors; and
- ! Exempt from prior authorization providers with an 80% approval rate of prior authorization requests over the previous 12 months, and conduct annual reevaluation of a provider's eligibility for the exemption.

If a carrier or organization fails to make a determination within the time required or fails to apply prior authorization requirements or exempt providers from prior authorization requirements, the request is deemed approved.

An approved prior authorization request is valid for at least 180 days and continues for the duration of the prescribed or ordered course of treatment and the covered person's plan year.

The commissioner of insurance is authorized to adopt rules as necessary to implement the bill.

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- 1 *Be it enacted by the General Assembly of the State of Colorado:*
- 2           **SECTION 1. Legislative declaration.** (1) The general assembly
- 3 finds and declares that:
- 4           (a) The provider-patient relationship is paramount and should not
- 5 be subject to intrusion by a third party;
- 6           (b) Prior authorization programs can prioritize potential cost
- 7 savings ahead of optimal patient care;
- 8           (c) Prior authorization programs should not be permitted to hinder
- 9 patient care or intrude on the practice of a health care profession; and
- 10           (d) Prior authorization programs must include the use of written,

1 clinical criteria and reviews by appropriate providers to ensure a fair  
2 process for patients.

3 **SECTION 2.** In Colorado Revised Statutes, **add** 10-16-112.5 as  
4 follows:

5 **10-16-112.5. Prior authorization for health care services -**  
6 **disclosures and notice - determination deadlines - criteria - limits and**  
7 **exceptions - definitions - rules. (1) Applicability. (a) ON OR AFTER**  
8 JANUARY 1, 2020, A CARRIER OR, IF A CARRIER CONTRACTS WITH A  
9 PRIVATE UTILIZATION REVIEW ORGANIZATION TO PERFORM PRIOR  
10 AUTHORIZATION FOR HEALTH CARE SERVICES, THE ORGANIZATION SHALL  
11 USE THE PRIOR AUTHORIZATION PROCESS AND COMPLY WITH THE  
12 REQUIREMENTS SPECIFIED IN THIS SECTION. EXCEPT AS OTHERWISE  
13 SPECIFIED IN THIS SECTION, THIS SECTION APPLIES TO PRIOR  
14 AUTHORIZATION REQUESTS FOR HEALTH CARE SERVICES, EXCLUDING  
15 REQUESTS FOR DRUG BENEFITS PURSUANT TO SECTION 10-16-124.5.

16 (b) THIS SECTION DOES NOT APPLY TO:

17 (I) A NONPROFIT HEALTH MAINTENANCE ORGANIZATION WITH  
18 RESPECT TO MANAGED CARE PLANS THAT PROVIDE A MAJORITY OF  
19 COVERED PROFESSIONAL SERVICES THROUGH A SINGLE CONTRACTED  
20 MEDICAL GROUP;

21 (II) A NONPROFIT HEALTH MAINTENANCE ORGANIZATION  
22 OPERATED BY OR UNDER THE CONTROL OF THE DENVER HEALTH AND  
23 HOSPITAL AUTHORITY CREATED BY ARTICLE 29 OF TITLE 25 OR ANY  
24 SUBSIDIARY OF THE AUTHORITY; OR

25 (III) CARRIERS, ORGANIZATIONS, AND MEDICAL BENEFITS SUBJECT  
26 TO THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO  
27 47 OF TITLE 8.

1           **(2) Disclosure of requirements - notice of changes.** (a) (I) A  
2 CARRIER SHALL MAKE CURRENT PRIOR AUTHORIZATION REQUIREMENTS  
3 AND RESTRICTIONS, INCLUDING WRITTEN, CLINICAL CRITERIA, READILY  
4 ACCESSIBLE ON THE CARRIER'S WEBSITE. THE PRIOR AUTHORIZATION  
5 REQUIREMENTS MUST BE DESCRIBED IN DETAIL AND IN CLEAR AND EASILY  
6 UNDERSTANDABLE LANGUAGE.

7           (II) IF A CARRIER CONTRACTS WITH A PRIVATE UTILIZATION  
8 REVIEW ORGANIZATION TO PERFORM PRIOR AUTHORIZATION FOR HEALTH  
9 CARE SERVICES, THE ORGANIZATION SHALL PROVIDE ITS PRIOR  
10 AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, AS REQUIRED BY THIS  
11 SUBSECTION (2), TO THE CARRIER WITH WHOM THE ORGANIZATION  
12 CONTRACTED, AND THAT CARRIER SHALL POST THE ORGANIZATION'S PRIOR  
13 AUTHORIZATION REQUIREMENTS AND RESTRICTIONS ON ITS WEBSITE.

14           (III) WHEN POSTING PRIOR AUTHORIZATION REQUIREMENTS AND  
15 RESTRICTIONS PURSUANT TO THIS SUBSECTION (2)(a) OR SUBSECTION  
16 (2)(b) OF THIS SECTION, A CARRIER IS NEITHER REQUIRED TO POST NOR  
17 PROHIBITED FROM POSTING THE PRIOR AUTHORIZATION REQUIREMENTS  
18 AND RESTRICTIONS ON A PUBLIC-FACING PORTION OF ITS WEBSITE.

19           (b) IF A CARRIER OR ORGANIZATION INTENDS TO IMPLEMENT A NEW  
20 PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION OR TO AMEND AN  
21 EXISTING REQUIREMENT OR RESTRICTION, THE CARRIER OR ORGANIZATION  
22 SHALL:

23           (I) NOTIFY ANY PARTICIPATING PROVIDERS OF THE NEW OR  
24 AMENDED REQUIREMENT OR RESTRICTION IN THE MANNER AND WITHIN  
25 THE TIME SPECIFIED IN SECTION 25-37-102 (9)(c) OR 25-37-104 (1), AS  
26 APPLICABLE; AND

27           (II) UPDATE THE PRIOR AUTHORIZATION INFORMATION POSTED ON

1 THE CARRIER'S WEBSITE PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION  
2 TO REFLECT THE NEW OR AMENDED PRIOR AUTHORIZATION REQUIREMENT  
3 OR RESTRICTION BEFORE IMPLEMENTING THE NEW OR AMENDED  
4 REQUIREMENT OR RESTRICTION.

5 (c) (I) A CARRIER SHALL POST, ON A PUBLIC-FACING PORTION OF  
6 ITS WEBSITE, DATA REGARDING APPROVALS AND DENIALS OF PRIOR  
7 AUTHORIZATION REQUESTS, INCLUDING REQUESTS FOR DRUG BENEFITS  
8 PURSUANT TO SECTION 10-16-124.5, IN A READILY ACCESSIBLE FORMAT  
9 AND THAT INCLUDE THE FOLLOWING CATEGORIES, IN THE AGGREGATE:

- 10 (A) PROVIDER SPECIALTY;
- 11 (B) MEDICATION OR DIAGNOSTIC TEST OR PROCEDURE;
- 12 (C) REASON FOR DENIAL; AND
- 13 (D) DENIALS SPECIFIED UNDER SUBSECTION (2)(c)(I)(C) OF THIS  
14 SECTION THAT ARE OVERTURNED ON APPEAL.

15 (II) AN ORGANIZATION THAT PROVIDES PRIOR AUTHORIZATION FOR  
16 A CARRIER SHALL PROVIDE THE DATA SPECIFIED IN SUBSECTION (2)(c)(I)  
17 OF THIS SECTION TO THE CARRIER WITH WHOM THE ORGANIZATION  
18 CONTRACTED, AND THE CARRIER SHALL POST THE ORGANIZATION'S DATA  
19 ON ITS WEBSITE.

20 (III) CARRIERS AND ORGANIZATIONS SHALL USE THE DATA  
21 SPECIFIED IN THIS SUBSECTION (2)(c) TO REFINE AND IMPROVE THEIR  
22 UTILIZATION MANAGEMENT PROGRAMS.

23 (3) **Nonurgent and urgent health care services - timely  
24 determination - notice of determination - deemed approved.**

25 (a) EXCEPT AS PROVIDED IN SUBSECTION (3)(b) OF THIS SECTION, A PRIOR  
26 AUTHORIZATION REQUEST IS DEEMED GRANTED IF A CARRIER OR  
27 ORGANIZATION FAILS TO:

1 (I) (A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN FIVE  
2 BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS  
3 APPROVED, DENIED, OR INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE  
4 SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED  
5 PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO  
6 PROCESS THE REQUEST; OR

7 (B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN FIVE  
8 BUSINESS DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION  
9 REQUIRED BY THE CARRIER OR ORGANIZATION PURSUANT TO SUBSECTION  
10 (3)(a)(I)(A) OF THIS SECTION, THAT THE REQUEST IS APPROVED OR DENIED;  
11 AND

12 (II) FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT HEALTH  
13 CARE SERVICES:

14 (A) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO  
15 BUSINESS DAYS BUT NOT LONGER THAN SEVENTY-TWO HOURS AFTER  
16 RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED, DENIED, OR  
17 INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL  
18 INFORMATION, CONSISTENT WITH CRITERIA POSTED PURSUANT TO  
19 SUBSECTION (2)(a) OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE  
20 REQUEST; OR

21 (B) NOTIFY THE PROVIDER AND COVERED PERSON, WITHIN TWO  
22 BUSINESS DAYS BUT NOT LONGER THAN SEVENTY-TWO HOURS AFTER  
23 RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE CARRIER OR  
24 ORGANIZATION PURSUANT TO SUBSECTION (3)(a)(II)(A) OF THIS SECTION,  
25 THAT THE REQUEST IS APPROVED OR DENIED.

26 (b) IF A CARRIER OR ORGANIZATION NOTIFIES THE PROVIDER AND  
27 COVERED PERSON PURSUANT TO SUBSECTION (3)(a)(I)(A) OR (3)(a)(II)(A)

1 OF THIS SECTION THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE  
2 AND THAT ADDITIONAL INFORMATION IS REQUIRED, THE PROVIDER SHALL  
3 SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS  
4 AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR ORGANIZATION. IF  
5 THE PROVIDER FAILS TO SUBMIT THE REQUIRED ADDITIONAL INFORMATION  
6 WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST  
7 IS NOT DEEMED GRANTED PURSUANT TO SUBSECTION (3)(a) OF THIS  
8 SECTION. AFTER RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION,  
9 THE CARRIER OR ORGANIZATION SHALL RESPOND TO THE PRIOR  
10 AUTHORIZATION REQUEST IN ACCORDANCE WITH SUBSECTION (3)(a)(I)(B)  
11 OF THIS SECTION OR, FOR A PRIOR AUTHORIZATION REQUEST FOR URGENT  
12 HEALTH CARE SERVICES, SUBSECTION (3)(a)(II)(B) OF THIS SECTION.

13 [REDACTED]  
14 (c) (I) WHEN NOTIFYING THE PROVIDER OF THE DETERMINATION  
15 ON A PRIOR AUTHORIZATION REQUEST, THE CARRIER OR ORGANIZATION  
16 SHALL PROVIDE A UNIQUE PRIOR AUTHORIZATION NUMBER ATTRIBUTABLE  
17 TO THAT REQUEST AND THE PARTICULAR HEALTH CARE SERVICE THAT IS  
18 THE SUBJECT OF THE REQUEST.

19 (II) IF THE CARRIER OR ORGANIZATION DENIES A PRIOR  
20 AUTHORIZATION REQUEST BASED ON A GROUND SPECIFIED IN SECTION  
21 10-16-113 (3)(a), THE NOTIFICATION IS SUBJECT TO THE REQUIREMENTS OF  
22 SECTION 10-16-113 (3)(a) AND COMMISSIONER RULES ADOPTED PURSUANT  
23 TO THAT SECTION AND MUST INCLUDE INFORMATION CONCERNING  
24 WHETHER THE CARRIER OR ORGANIZATION REQUIRES AN ALTERNATIVE  
25 TREATMENT, TEST, PROCEDURE, OR MEDICATION.

26 (d) THIS SUBSECTION (3) DOES NOT APPLY TO PRIOR  
27 AUTHORIZATION REQUESTS FOR DRUG BENEFITS THAT ARE SUBJECT TO

1 SECTION 10-16-124.5; EXCEPT THAT SUBSECTION (3)(c)(II) OF THIS  
2 SECTION APPLIES TO PRIOR AUTHORIZATION REQUESTS FOR DRUG  
3 BENEFITS.

4 (4) **Criteria, limits, and exceptions.** (a) CARRIERS AND  
5 ORGANIZATIONS SHALL:

6 (I) USE PRIOR AUTHORIZATION CRITERIA THAT ARE CURRENT,  
7 CLINICALLY BASED, ALIGNED WITH OTHER QUALITY INITIATIVES OF THE  
8 CARRIER OR ORGANIZATION, AND ALIGNED WITH OTHER CARRIERS' AND  
9 ORGANIZATIONS' PRIOR AUTHORIZATION CRITERIA FOR THE SAME HEALTH  
10 CARE SERVICES;

11 (II) ENSURE THAT PRIOR AUTHORIZATION REQUESTS ARE  
12 REVIEWED BY APPROPRIATE PROVIDERS; AND

13 (III) MAKE ELIGIBILITY, BENEFIT COVERAGE, AND MEDICAL POLICY  
14 DETERMINATIONS AS PART OF THE PRIOR AUTHORIZATION PROCESS.

15 (b) (I) CARRIERS AND ORGANIZATIONS SHALL CONSIDER LIMITING  
16 THE USE OF PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR  
17 ORDERING PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR  
18 PEERS AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS  
19 AND PRESENT OPPORTUNITIES FOR IMPROVEMENT IN ADHERENCE TO THE  
20 CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

21 (II) (A) A CARRIER OR ORGANIZATION MAY OFFER PROVIDERS  
22 WITH A HISTORY OF ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S  
23 PRIOR AUTHORIZATION REQUIREMENTS AT LEAST ONE ALTERNATIVE TO  
24 PRIOR AUTHORIZATION, INCLUDING AN EXEMPTION FROM PRIOR  
25 AUTHORIZATION REQUIREMENTS FOR A PROVIDER THAT HAS AT LEAST AN  
26 EIGHTY PERCENT APPROVAL RATE OF PRIOR AUTHORIZATION REQUESTS  
27 OVER THE IMMEDIATELY PRECEDING TWELVE MONTHS. AT LEAST



1 ANNUALLY, A CARRIER OR ORGANIZATION SHALL REEXAMINE A  
2 PROVIDER'S PRESCRIBING OR ORDERING PATTERNS AND REEVALUATE THE  
3 PROVIDER'S STATUS FOR EXEMPTION FROM OR OTHER ALTERNATIVE TO  
4 PRIOR AUTHORIZATION REQUIREMENTS PURSUANT TO THIS SUBSECTION  
5 (4)(b)(II).

6 (B) THE CARRIER OR ORGANIZATION SHALL INFORM THE PROVIDER  
7 OF THE PROVIDER'S EXEMPTION STATUS AND PROVIDE INFORMATION ON  
8 THE DATA CONSIDERED AS PART OF ITS REEXAMINATION OF THE  
9 PROVIDER'S PRESCRIBING OR ORDERING PATTERNS FOR THE  
10 TWELVE-MONTH PERIOD OF REVIEW.

11 [REDACTED]

12 (5) **Duration of approval.** (a) UPON APPROVAL BY THE CARRIER  
13 OR ORGANIZATION, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE  
14 HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL AND CONTINUES  
15 FOR THE DURATION OF THE AUTHORIZED COURSE OF TREATMENT. EXCEPT  
16 AS PROVIDED IN SUBSECTION (5)(b) OF THIS SECTION, ONCE APPROVED, A  
17 CARRIER OR ORGANIZATION SHALL NOT RETROACTIVELY DENY THE PRIOR  
18 AUTHORIZATION REQUEST FOR A HEALTH CARE SERVICE.

19 (b) IF THERE IS A CHANGE IN COVERAGE OF OR APPROVAL CRITERIA  
20 FOR A PREVIOUSLY APPROVED HEALTH CARE SERVICE, THE CHANGE IN  
21 COVERAGE OR APPROVAL CRITERIA DOES NOT AFFECT A COVERED PERSON  
22 WHO RECEIVED PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF  
23 THE CHANGE FOR THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR.

24 (c) SUBSECTIONS (5)(a) AND (5)(b) OF THIS SECTION DO NOT APPLY  
25 IF:

- 26 (I) THE PRIOR AUTHORIZATION APPROVAL WAS BASED ON FRAUD;
- 27 (II) THE PROVIDER NEVER PERFORMED THE SERVICES THAT WERE

1 REQUESTED FOR PRIOR AUTHORIZATION;

2 (III) THE SERVICE PROVIDED DID NOT ALIGN WITH THE SERVICE  
3 THAT WAS AUTHORIZED;

4 (IV) THE PERSON RECEIVING THE SERVICE NO LONGER HAD  
5 COVERAGE UNDER THE HEALTH COVERAGE PLAN ON OR BEFORE THE DATE  
6 THE SERVICE WAS DELIVERED; OR

7 (V) THE COVERED PERSON'S BENEFIT MAXIMUMS WERE REACHED  
8 ON OR BEFORE THE DATE THE SERVICE WAS DELIVERED.

9 (6) **Rules.** THE COMMISSIONER MAY ADOPT RULES AS NECESSARY  
10 TO IMPLEMENT THIS SECTION.

11 (7) **Definitions.** AS USED IN THIS SECTION:

12 (a) "APPROVAL" MEANS A DETERMINATION BY A CARRIER OR  
13 ORGANIZATION THAT A HEALTH CARE SERVICE HAS BEEN REVIEWED AND,  
14 BASED ON THE INFORMATION PROVIDED, SATISFIES THE CARRIER'S OR  
15 ORGANIZATION'S REQUIREMENTS FOR MEDICAL NECESSITY AND  
16 APPROPRIATENESS AND THAT PAYMENT WILL BE MADE FOR THAT HEALTH  
17 CARE SERVICE.

18 (b) "CLINICAL CRITERIA" MEANS THE WRITTEN POLICIES, WRITTEN  
19 SCREENING PROCEDURES, DRUG FORMULARIES OR LISTS OF COVERED  
20 DRUGS, DETERMINATION RULES, DETERMINATION ABSTRACTS, CLINICAL  
21 PROTOCOLS, PRACTICE GUIDELINES, MEDICAL PROTOCOLS, AND OTHER  
22 CRITERIA OR RATIONALE USED BY THE CARRIER OR ORGANIZATION TO  
23 DETERMINE THE NECESSITY AND APPROPRIATENESS OF HEALTH CARE  
24 SERVICES.

25 (c) "MEDICAL NECESSITY" MEANS A DETERMINATION BY THE  
26 CARRIER THAT A PRUDENT PROVIDER WOULD PROVIDE A PARTICULAR  
27 COVERED HEALTH CARE SERVICE TO A PATIENT FOR THE PURPOSE OF

1 PREVENTING, DIAGNOSING, OR TREATING AN ILLNESS, INJURY, DISEASE, OR  
2 SYMPTOM IN A MANNER THAT IS:

3 (I) IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF  
4 MEDICAL PRACTICE AND APPROVED BY THE FEDERAL FOOD AND DRUG  
5 ADMINISTRATION OR OTHER REQUIRED AGENCY;

6 (II) CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY,  
7 EXTENT, SERVICE SITE, AND LEVEL AND DURATION OF SERVICE;

8 (III) KNOWN TO BE EFFECTIVE IN IMPROVING HEALTH, AS PROVEN  
9 BY SCIENTIFIC EVIDENCE;

10 (IV) THE MOST APPROPRIATE SUPPLY, SETTING, OR LEVEL OF  
11 SERVICE THAT CAN BE SAFELY PROVIDED GIVEN THE PATIENT'S CONDITION  
12 AND THAT CANNOT BE OMITTED;

13 (V) NOT EXPERIMENTAL OR INVESTIGATIONAL;

14 (VI) NOT MORE COSTLY THAN AN ALTERNATIVE DRUG, SERVICE,  
15 SERVICE SITE, OR SUPPLY THAT IS NOT CONTRAINDICATED FOR THE  
16 PATIENT'S CONDITION OR SAFETY AND IS AT LEAST AS LIKELY TO PRODUCE  
17 EQUIVALENT THERAPEUTIC OR DIAGNOSTIC RESULTS AS TO THE DIAGNOSIS  
18 OR TREATMENT OF AN ILLNESS, INJURY, DISEASE, OR SYMPTOM; AND

19 (VII) NOT PRIMARILY FOR THE ECONOMIC BENEFIT OF CARRIERS  
20 AND PURCHASERS OR FOR THE CONVENIENCE OF THE PATIENT, TREATING  
21 PROVIDER, OR OTHER PROVIDER.

22 (d) "PRIOR AUTHORIZATION" MEANS THE PROCESS BY WHICH A  
23 CARRIER OR ORGANIZATION DETERMINES THE MEDICAL NECESSITY AND  
24 APPROPRIATENESS OF OTHERWISE COVERED HEALTH CARE SERVICES PRIOR  
25 TO THE RENDERING OF THE SERVICES. "PRIOR AUTHORIZATION" INCLUDES  
26 PREADMISSION REVIEW, PRETREATMENT REVIEW, UTILIZATION REVIEW,  
27 AND CASE MANAGEMENT AND A CARRIER'S OR ORGANIZATION'S

1 REQUIREMENT THAT A COVERED PERSON OR PROVIDER NOTIFY THE  
2 CARRIER OR ORGANIZATION PRIOR TO RECEIVING OR PROVIDING A HEALTH  
3 CARE SERVICE.

4 (e) "PRIVATE UTILIZATION REVIEW ORGANIZATION" OR  
5 "ORGANIZATION" HAS THE SAME MEANING AS SET FORTH IN SECTION  
6 10-16-112 (1)(a).

7 (f) "URGENT HEALTH CARE SERVICE" MEANS A HEALTH CARE  
8 SERVICE THAT, IN THE OPINION OF THE PROVIDER BASED ON THE COVERED  
9 PERSON'S MEDICAL CONDITION, IF SUBJECTED TO THE PRIOR  
10 AUTHORIZATION TIME PERIOD FOR A NONURGENT HEALTH CARE SERVICE,  
11 COULD:

12 (I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED  
13 PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM  
14 FUNCTION;

15 (II) FOR A PERSON WITH A PHYSICAL OR MENTAL DISABILITY,  
16 CREATE AN IMMINENT AND SUBSTANTIAL LIMITATION ON THE PERSON'S  
17 EXISTING ABILITY TO LIVE INDEPENDENTLY; OR

18 (III) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT  
19 CANNOT BE ADEQUATELY MANAGED WITHOUT THE PARTICULAR HEALTH  
20 CARE SERVICE.

21 **SECTION 3.** In Colorado Revised Statutes, 10-16-112, **amend**  
22 (1)(a) as follows:

23 **10-16-112. Private utilization review - health care coverage**  
24 **entity responsibility.** (1) As used in this section, unless the context  
25 otherwise requires:

26 (a) "Private utilization review organization" means an entity, other  
27 than a hospital or public reviewer following federal guidelines, ~~which~~

1 THAT conducts utilization review OR REVIEWS AND MAKES  
2 DETERMINATIONS ON PRIOR AUTHORIZATION REQUESTS FOR HEALTH CARE  
3 SERVICES AS DESCRIBED IN SECTION 10-16-112.5. This definition shall not  
4 apply to any independent medical examination provided for in any policy  
5 of insurance.

6 **SECTION 4. Act subject to petition - effective date -**  
7 **applicability.** (1) This act takes effect at 12:01 a.m. on the day following  
8 the expiration of the ninety-day period after final adjournment of the  
9 general assembly (August 2, 2019, if adjournment sine die is on May 3,  
10 2019); except that, if a referendum petition is filed pursuant to section 1  
11 (3) of article V of the state constitution against this act or an item, section,  
12 or part of this act within such period, then the act, item, section, or part  
13 will not take effect unless approved by the people at the general election  
14 to be held in November 2020 and, in such case, will take effect on the  
15 date of the official declaration of the vote thereon by the governor.

16 (2) This act applies to prior authorization requests for health care  
17 services submitted on or after January 1, 2020.