WSCA
WASHINGTON STATE CHIROPRACTIC ASSOCIATION

August 9, 2016

Office of the Insurance Commissioner
Attention: Jim Freeburg
RE: Prior authorization process and transparency rule (R-2016-19)

The Washington State Chiropractic Association (WSCA) submits the following public comment regarding the stakeholder draft rules regarding prior authorization processes. We appreciate that the agency is taking action on this process that affects patient care and has created additional work for the provider delivering the care.

WAC 284-43-0160 (new definitions)

In the definition of "prior authorization" the proposed language references "request made in advance of the patient obtaining medical care or services." This definition is not consistent with RCW 48.43.016 which goes into effect January 1, 2017 and states:

*(2) **A health carrier may not require prior authorization for an evaluation and management visit or an initial treatment** visit with a contracting provider in a new episode of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.*

In Subchapter D – Utilization Review and Prior Authorization
WAC 284-43-2050 (1)
This section states that the issuers must make sufficient information available online to participating providers or as "mutually agreed to by all parties..."

The WSCA supports a requirement that all prior authorization materials be available to providers online. Since the provider agreements are not truly negotiated, and are instead a "take-it-or-leave-it" document, we believe that online availability should be the minimal requirement of an issuer and/or its contracted entity.

WAC 284-43-2050 (1) (a)

1. The language defined in this section references the "provider." However, that sentence references actions by the issuer. In subsection (a) the sentence should read "When a provider makes a request for prior authorization, the "ISSUER" notice must be clear and explain..."
2. The WSCA supports the proposed requirement that an issuer or its hired entity provide justification for their decision(s) when care is limited or denied. We also

21400 International Blvd. Ste. #207
SeaTac, WA 98198

206•878•6055
1•800•824•4918
Fax 206•878•8699
www.chirohealth.org
wsca@chirohealth.org

support that the decision be communicated both to the provider and the enrollee.

3. The WSCA supports the proposed requirement that the decision-maker's credentials and name are known to both the provider and the patient when care is approved, limited or denied.

WAC 284-43-2050 (6) (a) (ii)

In regard to the proposed rule regarding timelines for insufficient information submitted:

1. The WSCA is concerned that the issuer and their hired entities do not allow for a complete diagnostic picture to be submitted in the prior authorization process. This lack of information upon initial submission results in inadequate authorizations or inappropriate denial of care. Contractors that are currently being used by at least two issuers are limiting information submission to only one patient diagnosis and explicitly stating they do not want copies of medical records.
2. If the issuers challenge the timelines proposed for authorizations without sufficient information and recommend more than the proposed seven days, the WSCA requests that the expiration of the authorization, referenced in the next section, not occur prior to sixty (60) days.

WAC 284-43-2050 (7)

1. The WSCA supports the requirement that prior authorization expirations shall not be sooner than 45 days from the date of approval. Third party contractors are regularly dating the authorization effective date as that of the initial request. This process allows for the contractor to capture the initial date of service allowed by law, but then creates a gap in care which consumes a portion of the authorization timeframe. This interrupts effective patient care.
2. Additionally, within the proposed authorization timelines, providers are experiencing limitation of who, within the network, a patient is allowed to see for care. The authorizations are specific to a provider that initiates the authorization and their tax ID number instead of specific to a patient and their authorized care. WAC 284-43-5440 (2) (j) states:

   > *Ensure that where medically appropriate and consistent with the health benefit plan's contract terms, an enrollee is not unreasonably restricted as to the site of service delivery.*

WAC 284-43-2050 (8) (e, f)

1. This section refers to medical necessity. In WAC 284-43-5440 the details of medical necessity are called out. However; the WSCA recommends that the

proposed rules should specifically state that the medical necessity definitions used by the contracted entity performing prior authorization services for an issuer be an identical match to those used by the issuer themselves.

Current example: Premera has a medical necessity definition (revised 2/16) for Physical Medicine & Rehabilitation services for Chiropractic which are different than the clinical guidelines definitions (12/15) used by eviCore, their contracted entity for prior authorization services. Which document is the provider expected to follow?

2. The experiences reported by our members indicate that there is a lack of adherence to the current medical necessity rule WAC 284-43-5440 (h) which references provider clinical judgement. And it states:

   (h) Include consideration of the treating provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee;
   (i) Identify by role who will participate in the issuer's medical necessity decision-making process; and...

   Example: A provider cannot adequately express the patient's condition with the systems currently used by the contracted entity. Prior authorizations decisions should defer to the clinical judgment of the provider as documented in the patient records and clinical outcomes, not the EXPECTED outcome of a contracted entity whose guidelines appear to be identical for every condition and are not specific to the patient's functional improvements.

WAC 284-43-2050 (9)

This section references reimbursement for costs of preparing medical records duplication for reviews. However, the draft doesn't take into consideration the dramatic shift of duties which have always been the administrative responsibility of the issuer. In the case of the prior authorization process the administrative burden has now been shifted to the provider. It is appropriate to compensate providers for the administrative burden that is now costing them a great deal of time online processing the many screen shots required to request the authorization – even when the process doesn't allow for sufficient information to assure an approval for care, as well as extensive telephonic and written communications to provide adequate detail for a successful authorization request. This rule should consider compensation to the provider for this administrative burden.

In a final comment to the stakeholder draft of the proposed rule the WSCA does not see a process where the provider or patient has the ability to challenge the prior authorization process. Since the decisions are made by an outside company in most cases it seems at least appropriate that one of two things occur:

1. The issuer handle all disputes of prior authorization and that they cannot direct the provider and/or patient back to the contractor performing the authorizations, where they may be endlessly redirected between the two companies. Or,
2. That the issuer and contractor provide consistent and clear procedures for appeals by either a patient or a provider with name, address, phone number, and fax.

What happens currently is that the provider has to resubmit a prior authorization request and hope that a subsequent request is approved.

The WSCA appreciates the opportunity to respond to the current stakeholder draft. If you have any questions please do not hesitate to contact me at 206-878-6055.

Respectfully submitted,

Lori L. Grassi

cc: Garry W. Baldwin, DC, WSCA President
David Butters, DC, WSCA, Political Director