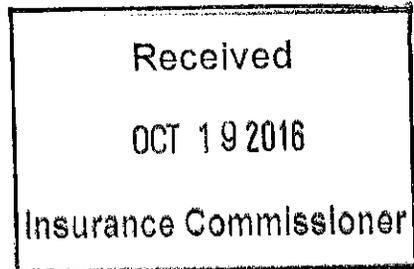


UW Medicine



October 13, 2016

Hon. Mike Kreidler
Office of Insurance Commissioner
PO Box 40258
Olympia, WA 98504-0258

RE: Prior Authorization Rulemaking - UW Medicine's Comments to 2nd Stakeholder Draft

Dear Commissioner Kreidler:

UW Medicine again applauds the efforts of you and your staff to reform the health insurance prior authorization process in Washington. The updates reflected in your second stakeholder draft (released on September 23, 2016) serve to further balance and streamline prior authorization practices in a manner that will lead to stronger communication between providers and insurers, more efficient utilization of resources, and better value for Washington's consumers of health insurance. UW Medicine's brief comments and preferred edits are enclosed. Thank you again for allowing UW Medicine the opportunity to participate in this process.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline Cabe".

JACQUELINE L. CABE
Chief Financial Officer, UW Medicine
Vice President for Medical Affairs, UW

enclosure

UW Medicine Administration

1959 NE Pacific Street Box 356350 Seattle, WA 98195-6350 206.543.7718

Name of rule: Prior authorization process and transparency
Rule number: 2016-19
Stakeholder draft released on: September 23, 2016
For questions or comments, please contact: Jim Freeburg
Send comments to: rulesc@oic.wa.gov
Comment deadline: October 14, 2016

Comment [LME1]: UW Medicine's comments and preferred edits.

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WAC 284-43-2060 Extenuating circumstances (New section)

(1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018.

(2) Carriers or ~~a carrier's their~~ designated or contracted representative must allow the retrospective review of services when an extenuating circumstance prevents a ~~provider~~ from obtaining a required prior authorization before a service is delivered. For purposes of this section, an "extenuating circumstance" means a situation where a carrier must not deny a provider's claim for lack of prior authorization if the services are otherwise eligible for reimbursement. The carrier's or ~~carrier's their~~ designated or contracted representative's policy on extenuating circumstances ~~policy~~ must address, at a minimum, ~~but is not limited to~~ situations where:

Comment [LME2]: The rule should clarify that "Provider" indicates a medical professional and/or facility. (In CMS rules, the term "Provider" indicates a professional practitioner or group. If the OIC's intent is to also include facility, this should be clarified.)

(a) ~~Under the given circumstances, the~~ provider is unable to reasonably expect the need for the ~~outpatient~~ service in question prior to performing the service;

(b) Under the given circumstances, ~~the~~ provider is unable to reasonably determine ~~know~~ which carrier or ~~carrier's their~~ designated or contracted representative to request prior authorization from; and

(c) Under the given circumstances, ~~the~~ provider reasonably does not have ~~sufficient enough~~ time to request a prior authorization before performing the service.

Comment [LME3]: Extenuating circumstances of this variety routinely (and unexpectedly) occur in inpatient situations as well as outpatient.

(3) A carrier or ~~its their~~ designated or contracted representative may require providers to follow certain procedures in order for services to qualify as an extenuating circumstance, such as requirements for documentation or a timeframe for claims submission. Claims related to an extenuating circumstance may still be reviewed for medical necessity.

(4) This section does not apply to services covered under an enrollee's pharmacy benefit.

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