

Stakeholder draft

Name of rule: Prior authorization process and transparency

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WAC 284-43-0160 (New definitions)

"Expedited prior authorization request" means any request for approval of a health care service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

"Immediate prior authorization request" means any request for approval of treatment health care service where the passage of time without treatment would, in the judgement of the provider, result in an imminent emergency room visit or hospital admission, and deterioration of the enrollee's health status. Immediate prior authorization requests includes "urgent prior authorization requests."

"Pre-determination request" means a voluntary request from an enrollee provider, or facility for a carrier or their designated or contracted representative to determine if a health care service is a covered benefit and medically necessary in relation to the applicable health plan.

"Pre-service requirement" means any requirement that a carrier places on a provider or facility that may limit their ability to deliver a service that requires prior authorization. Examples include limits on

the type of rendering provider, site of care/place of service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.

"Prior authorization" is a mandatory process that a carrier or their designated or contracted representative requires a provider or facility to follow to determine if a health care service is a covered benefit and meets the clinical requirements for medical necessity, appropriateness, level of care, and effectiveness in relation to the applicable health plan. Prior authorization occurs before the service is rendered. For purposes of this rule, any term used by a carrier or their designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "pre-authorization," "prospective review," "preauthorization," or "precertification."

"Standard prior authorization request" means any request for approval of a health care service where the request is made in advance of the enrollee obtaining medical care or services.

Subchapter D - Utilization Review and Prior Authorization

WAC 284-43-2050 Prior authorization processes (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) Each carrier or their designated or contracted representative must maintain a documented prior authorization program description and use medically acceptable screening criteria. Carriers or their designated or contracted representative must make determinations in accordance with currently acceptable medical or health care practices. The program must include a method for reviewing and updating criteria. A carrier or their designated or contracted representative must not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

(3) The prior authorization program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance in addition to the requirements of this chapter. The prior authorization program must have staff who are

properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) Carriers or their designated or contracted representative must have a current and accurate online prior authorization system. The online system must be accessible to providers and facilities so that, prior to delivering a service, providers and facilities will have enough information to determine if a service is a covered benefit under the enrollee's health benefit plan and the information necessary to submit a complete prior authorization request. The online system must include sufficient information for a provider or facility to determine:

(a) If a service a covered benefit under the enrollee's health benefit plan;

(b) If a prior authorization request is necessary;

(c) If any preservice requirements apply; and

(d) If a prior authorization request is necessary, the following information:

(i) The clinical criteria used to evaluate the request; and

(ii) Any required documentation.

(5) In addition to other methods to process prior authorization requests, carriers or their designated or contracted representative that require prior authorization for services must have an electronic, interactive process that is browser-based to complete a prior authorization request.

(a) When a provider makes a request for the prior authorization, the response from the carrier or their designated or contracted representative must be clear and explain if it is approved or denied and the justification and basis for the decision including the criteria for the denial. The response must give the true and actual reason in clear and simple language so that the enrollee and the provider will not need to resort to additional research to understand the real reason for the action. Written notice of the decision must be communicated to the provider or facility, and the enrollee. The denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.

(b) A prior authorization approval notification must include sufficient information for the requesting provider or facility, and the enrollee, to know whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out of network provider or facility and disclose to the enrollee the financial implications for receiving services from an out of network provider or facility.

(6) Carriers or their designated or contracted representative are responsible for maintaining a system of documenting information and

supporting evidence submitted by providers and facilities while requesting prior authorization.

(a) Upon request of the provider or facility, carriers or their designated or contracted representative must remit to the provider or facility written acknowledgement of receipt of each document submitted by a provider or facility during the processing of a prior authorization request.

(b) When information is transmitted telephonically, the carrier or their designated or contracted representative must provide written acknowledgement of the information communicated by the provider or facility.

(7) Carriers or their designated or contracted representative that require prior authorization for any covered service must accept a prior authorization request from providers and facilities at any time, including outside normal business hours.

(8) Each carrier or their designated or contracted representative must have written policies and procedures to assure that prior authorization determinations are made within the appropriate timeframes.

(a) Time frames must be appropriate to the severity of the enrollee condition and the urgency of the need for treatment, as documented in the prior authorization request.

(b) If the request from the provider or facility is not accompanied by all necessary information, the carrier or their designated or contracted representative must inform the provider or facility what additional information is needed and the deadline for its submission as set forth in this section.

(9) The time frames for carrier or their designated or contracted representative prior authorization determination and notification are as follows:

(a) For immediate prior authorization requests:

(i) Within 60 minutes, or as stated in the provider contract, after eligibility and benefits have been verified and sufficient clinical information has been provided to the health plan.

(b) For standard prior authorization requests:

(i) If sufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier or their designated or contracted representative has 5 calendar days once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier or their designated or contracted representative has 5 calendar days to request additional information from the provider.

(A) The carrier or their designated or contracted representative must give a provider 5 calendar days to give the necessary information to the carrier or their designated or contracted representative.

(B) The carrier or their designated or contracted representative must then make a decision and give notification within 4 calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(c) For expedited prior authorization requests:

(i) If sufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier has 48 hours once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier or their designated or contracted representative has 24 hours to request additional information from the provider.

(A) The carrier or their designated or contracted representative must give a provider 48 hours to give the necessary information to the carrier or their designated or contracted representative.

(B) The carrier or their designated or contracted representative must then make a decision and give notification within 48 hours of the receipt of the information or the deadline for receiving information, whichever is sooner.

(10) Immediate prior authorization requests do not include the following situations:

(a) The service being requested had been pre-scheduled was not an emergency when scheduled, and no change in patient condition has occurred

(b) The request is for experimental or investigational services or a clinical trial

(c) The request is for the convenience of the patient's schedule or provider's schedule.

(d) The results of the requested service are not likely to lead to an immediate change in the patient's treatment.

(11) Each carrier or their designated or contracted representative when conducting prior authorization must:

(a) Accept any evidence-based information from a provider that will assist in the authorization process;

(b) Collect only the information necessary to authorize the health care service and maintain a process for the provider to submit such records;

(c) Not routinely request copies of medical records to render authorization;

(d) Require only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(e) Base review determinations on the medical information in the enrollee's records and obtained by the carrier up to the time of the review determination; and

(f) Use the medical necessity definition stated in the enrollee's health benefit plan.

(12) A prior authorization denial is an adverse benefit determination and is subject to the appeal process.

(13) Prior authorization determinations shall expire no sooner than 45 days from date of approval. This requirement does not supersede RCW 48.43.039.

(14) Each carrier must reimburse reasonable costs of medical record duplication for reviews.

(15) A carrier's obligation to comply with prior authorization requirements is non-delegable. The carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program.

(16) In limited circumstances when enrollees have to change plans due to a carrier's market withdrawal as defined in RCW 48.43.035(4)(d) and 48.43.038(3)(d), subsequent carriers or their designated or contracted representative must recognize the prior authorization of the previous carrier and ensure that the enrollee receives the initial service that was previously authorized as an in-network covered service. Carriers or their designated or contracted representative must recognize the prior authorization for at least 30 days or the expiration date of the original prior authorization, whichever is greater. Enrollee's must present proof of the prior authorization.

(17) Pre-determination notices must clearly disclose to the requesting provider or facility, and enrollee that the determination is not a prior authorization and does not guarantee services will be covered.

(18) Any carrier changes to a prior authorization procedure constitute a change to a provider contract as the term is used in Chapter 284-170 WAC and must be made as an amendment.

(19) Prior authorization for a facility to facility transport that requires prior authorization can be performed after the service is delivered. Authorization can only be based on information available to the carrier or their designated or contracted representative at the time of the prior authorization request.

(20) Carriers or their designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a clinically recognized course of treatment based upon a review of medical records in advance of seeing the enrollee.

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 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 their designated or contracted representative's extenuating circumstances policy must address, but is not limited to situations where:

(a) A provider is unable to expect the need for the outpatient service in question prior to performing the service;

(b) The provider is unable to know which carrier or their designated or contracted representative to request prior authorization from; and

(c) The provider does not have enough time to request a prior authorization

(3) A carrier or 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.

WAC 284-43-2000 Health care services utilization review—Generally.

(1) These definitions apply to this section:

(a) "Concurrent care review request" means any request for an extension of a previously authorized inpatient stay or a previously authorized ongoing outpatient service, e.g., physical therapy, home health, etc.

~~(b) "Immediate review request" means any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the provider, result in an imminent emergency room visit or hospital admission and deterioration of the patient's health status. Examples of situations that do not qualify under an immediate review request include, but are not limited to, situations where:~~

~~(i) The requested service was prescheduled, was not an emergency when scheduled, and there has been no change in the patient's condition;~~

~~(ii) The requested service is experimental or in a clinical trial;~~

~~(iii) The request is for the convenience of the patient's schedule or physician's schedule; and~~

~~(iv) The results of the requested service are not likely to lead to an immediate change in the patient's treatment.~~

~~(c) "Nonurgent preservice review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services and is not an urgent care request.~~

(d) "Postservice review request" means any request for approval of care or treatment that has already been received by the patient.

~~(e) "Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.~~

(2) Each issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Issuers must make clinical review criteria available upon request to participating providers. An issuer need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

(3) The utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(4) Each issuer when conducting utilization review must:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all patients reviewed;

(e) Require only the section(s) of the medical record during prospective review or concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For ~~prospective and~~ concurrent review, base review determinations solely on the medical information obtained by the issuer at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the attending physician or order provider at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the issuer is materially different from that which was reasonably available at the time of the original determination.

(5) Each issuer must reimburse reasonable costs of medical record duplication for reviews.

(6) Each issuer must have written procedures to assure that reviews and second opinions are conducted in a timely manner.

(a) Review time frames must be appropriate to the severity of the patient condition and the urgency of the need for treatment, as documented in the review request.

(b) If the review request from the provider is not accompanied by all necessary information, the issuer must tell the provider what additional information is needed and the deadline for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for issuer review determination and notification must be no less favorable than federal Department of Labor standards, as follows:

~~(i) For immediate request situations, within one business day when the lack of treatment may result in an emergency visit or emergency admission;~~

(ii) For concurrent review requests that are also urgent care review requests, as soon as possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments;

~~(iii) For urgent care review requests:~~

~~(A) The issuer must approve the request within forty eight hours if the information provided is sufficient to approve the claim;~~

~~(B) The issuer must deny the request within forty eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or~~

~~(C) Within twenty four hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination;~~

~~(I) The issuer must give the provider forty-eight hours to submit the requested information;~~

~~(II) The issuer must then approve or deny the request within forty-eight hours of the receipt of the requested additional information.~~

~~(iv) For nonurgent preservice review requests, including nonurgent concurrent review requests:~~

~~(A) The issuer must approve the request within five calendar days if the information is sufficient to approve the claim;~~

~~(B) The issuer must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or~~

~~(C) Within five calendar days, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination;~~

~~(I) The issuer must give the provider five calendar days to submit the requested additional information;~~

~~(II) The issuer must then approve or deny the request within four calendar days of the receipt of the additional information.~~

~~(v) For postservice review requests, within thirty calendar days.~~

~~(c) Notification of the determination must be provided as follows:~~

~~(i) Information about whether a request was approved or denied must be made available to the attending physician, ordering provider, facility, and covered person. Issuers must at a minimum make the information available on their web site or from their call center.~~

~~(ii) Whenever there is an adverse determination the issuer must notify the ordering provider or facility and the covered person. The issuer must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means. For an adverse determination involving an urgent care review request, the issuer may initially provide notice by phone, provided that a written or electronic notification meeting United States Department of Labor standards is furnished within seventy-two hours of the oral notification.~~

~~(d) As appropriate to the type of request, notification must include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.~~

~~(e) The frequency of reviews for the extension of initial determinations must be based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.~~

~~(7) No issuer may penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the issuer's determination with respect to coverage or payment for health care service.~~