# RULE-MAKING ORDER

**CR-103P (May 2009)**
**(Implements RCW 34.05.360)**

**Agency:** Office of the Insurance Commissioner

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

☐ **31 days after filing.**

☒ **Other (specify)** **January 1, 2017** **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

☐ **Yes** ☒ **No** **If Yes, explain:**

**Purpose:**

The rules are intended to streamline the prior authorization process. They will allow additional time for issuers to process a medical prior authorization request if insufficient information has been provided to them to make a decision.

Insurance Commissioner Matter No. R 2016-02

**Citation of existing rules affected by this order:**

Repealed:
Amended: WAC 284-43-2000
Suspended:

**Statutory authority for adoption:** RCW 48.02.060, RCW 48.43.510, RCW 48.165.0301

**Other authority:**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR **16-08-025** on March 29, 2016.

Describe any changes other than editing from proposed to adopted version:

Clarified the issuer's obligation to abide by specified timeframes by adding "The issuer" to the beginning of WAC 284-43-2000 (6)(b)(iii)(A), (6)(b)(iii)(B), (6)(b)(iv)(A), and (6)(b)(iv)(B).

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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**Date adopted:** May 16, 2016

**NAME (TYPE OR PRINT)**
Mike Kreidler

**SIGNATURE**

**TITLE**
Insurance Commissioner

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 16, 2016
TIME: 2:25 PM

WSR 16-11-074

**(COMPLETE REVERSE SIDE)**

**Note: If any category is left blank, it will be calculated as zero. No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Federal statute:** | New | | Amended | | Repealed | |
| **Federal rules or standards:** | New | | Amended | | Repealed | |
| **Recently enacted state statutes:** | New | | Amended | 1 | Repealed | |

**The number of sections adopted at the request of a nongovernmental entity:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | | Amended | | Repealed | |

**The number of sections adopted in the agency's own initiative:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | | Amended | 1 | Repealed | |

**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

| | | | | | | |
|---|---|---|---|---|---|---|
| | New | | Amended | | Repealed | |

**The number of sections adopted using:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Negotiated rule making:** | New | | Amended | | Repealed | |
| **Pilot rule making:** | New | | Amended | | Repealed | |
| **Other alternative rule making:** | New | | Amended | 1 | Repealed | |

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

**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 ((~~within forty-eight hours;~~)):

(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((~~, within five calendar days; or~~)):

(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.