OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Prior Authorization Processes

Concise Explanatory Statement
June 5, 2017

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Introduction

The Revised Code of Washington (RCW) 34.05.325(6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES:

1. Identifies the Commissioner's reasons for adopting the rule;

2. Describes the differences between the proposed rule and the final rule (other than editing changes) and the reasons for the difference;

3. Summarizes and responds to all comments that the OIC received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the OIC's reasons for not incorporating the change requested by the comment;

4. Must be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Reasons for adopting the rule

The Commissioner has determined that rules are necessary for transparency and consistency of access to covered health care services in the marketplace.. Currently, prior authorization processes are not streamlined and consumers are at risk of having delayed access to care because health carriers may require providers to use their specific process, rather than a universal process. With the rule, the Commissioner intends to streamline the marketplace's prior authorization minimum standards and ensure it is more transparent for consumers and providers.

Background

Existing regulations govern utilization review but they do not reflect the current practices in use by industry. Updates are necessary to ensure that providers have accurate and consistent information to request and receive a prior authorization on behalf of consumers. Increasingly, prior authorization is required by carriers before a provider can deliver a service to a consumer. Providers have raised a number of concerns regarding their ability to complete a prior authorization request including lost documentation, incomplete requirements, and inadequate review of requests.

The industry has been developing solutions to streamline the prior authorization process via a work group administered by OneHealthPort. The work group, made up of carriers and providers, has been developing best practice recommendations for prior authorization that describe an ideal method to process a prior authorization request. The work group does not have authority to mandate its recommendations and therefore they have not been universally adopted by health insurers. The rules require insurers to comply with the standards, that include recommendations of the work group, as adopted by the Commissioner.

Rule development process

The OIC worked closely with stakeholders to develop the rule. The OIC held three stakeholder meetings and released two stakeholder drafts prior to the release of the proposed rule (CR-102). Stakeholders were given three opportunities to provide written comments on the rule, in addition to the usual comment periods and public hearing provided for in the CR-101 and CR-102 phases.

To begin, the OIC announced on May 16, 2016 that it was soliciting comments from stakeholders regarding the challenges faced by consumers, providers, and carriers regarding prior authorization. This was prior to the release of the CR-101. Written comments were accepted until June 17, 2016. The OIC held a stakeholder meeting on June 28, 2016 to learn more about the concerns raised by stakeholders.

On June 17, 2016 the OIC filed a Pre-proposal Statement of Inquiry (CR-101) proposing to write a rule to streamline the prior authorization process. The comment period on the CR-101 was open until August 4, 2016.

On July 15, 2016, the OIC shared a draft with interested stakeholders. The comment period on this first stakeholder draft was open until August 17, 2016.

On August 8, 2016, OIC staff held a meeting to discuss the rule with stakeholders, answering questions and elaborating on various aspects of the rule.

On September 23, 2016, the OIC released a second stakeholder draft to the public. The comment period on the second stakeholder draft was open until October 14, 2016.

On October 5, 2016, OIC staff held its third public meeting to discuss the rule with stakeholders, answering questions and elaborating on various aspects of the rule.

Throughout the rulemaking process, the OIC worked closely with OneHealthPort's prior authorization work group to solicit feedback and increase stakeholder awareness of the rule.

On November 22, 2016, the OIC filed the proposed rulemaking (CR-102). The agency held a hearing on January 4, 2017.

After the release of the CR-102, the agency continued to work with stakeholders to address newly raised issues.

The OIC filed a CR-103P to adopt the rule on XX, 2017 and the rule went into effect 31 days later.

Resources consulted

OneHealthPort's Best Practice Recommendations on browser capabilities, extenuating circumstances, and PA timeframes

Ohio Senate Bill 129 from the 131st General Assembly

2015 Oregon Revised Statute Vol. 16 743B.420

General Statutes of Connecticut Title 38a Chapter 700c Sec. 38a-472g

Differences between proposed and final rule

Effective dates

The effective dates were changed in the final rule. The online requirements in WAC 284-43-2050 were originally proposed to take effect January 1, 2018. Under the new proposal, the online requirements will be effective November 1, 2019. Other sections (besides the definitions) will still be effective January 1, 2018, with the exception of the definitions, which will take effect 31 days after adoption.

WAC 284-43-0160

(34) Slight changes to the definition of prior authorization to account for more accurate representation of industry practices

(37) The definition of standard prior authorization request was changed to distinguish it from an expedited prior authorization request

WAC 284-43-2000

Changed "patient" to "enrollee" (throughout WAC 284-43-2000)

(6)(b) Rescinded deletion of and clarified timeframe for urgent inpatient services requiring concurrent review

WAC 284-43-2050

Several subsections were renumbered and reorganized for clarity. The references below are in relation to the CR-103 draft.

(1) Clarified that the section does not apply to prescription drug services

(2) Changed "medically acceptable" to evidence based. Additional requirements from elsewhere in the rule were moved into this subsection.

(3) Clarified requirement related to accreditation

(4) & (5) Clarified online process requirement, including adjusting effective date

(6) An exception was added for integrated delivery systems and clarity was added regarding the requirement for out-of-network providers

(10)(a)(i) and (b)(i) Clarified requirements related to the timeframes for a carrier to respond to a prior authorization request

(12) Clarified requirement related to the denial of a prior authorization request

(13) Clarified requirement related to the approval notification

(14) Clarified requirement that a provider or facility can appeal a prior authorization denial

(15) Deleted reference to reimbursing costs of medical record duplication

(16) Shortened carrier responsibility for honoring a previous carrier's prior authorization during a market withdrawal and clarified intent

(19) Clarified requirement related to predetermination requests

In addition, two restatements of existing law were deleted, including references to prior authorization in provider contracts and the reimbursement of medical record duplication.

WAC 284-43-2060 Clarified caption

(2) -> (8) Several changes were made to clarify the purpose of the extenuating circumstances section. The intent of the section was clarified, including the process for a provider or facility to notify the carrier of an extenuating circumstance. Other clarifications were made regarding participating providers and the exact circumstances that must be considered as an extenuating circumstance.

Responsiveness summary of comments

The OIC received numerous comments and suggestions regarding this rulemaking. The following information contains a description of the comments, the OIC's review of the comments, and information about whether the OIC included or rejected the comments. Numerous comments were repeated multiple times during the rulemaking process though repetitive comments are only addressed once. Comments received throughout the rulemaking process have been combined into the comments below.

Prior to the rulemaking process, the OIC received comments from:

- Arthritis Foundation
- Children's Therapy Center
- Department of Health's Children with Special Needs Program
- Empower Billing
- Evergreen Health
- Dr. Susan Hakeman
- Jason Hussey
- Kaiser
- Legacy Salmon Creek Medical Center
- Premera
- Providence
- Physical Therapy Association of Washington
- Seattle Cancer Care Alliance
- Seattle Children's Hospital
- University of Washington Medicine
- Vantage Physicians
- Virginia Mason
- Washington Academy of Eye Physicians and Surgeons
- Washington State Hospital Association
- Washington Speech-Language Hearing Association

- Washington State Medical Association
- Washington State Podiatric Medical Association
- Washington State Radiological Society

The following individuals and organizations provided comments on the notice of proposed rulemaking:

- Dr. Dennis Chong
- Kari Kelley
- Dr. Katherine Ottaway
- Community Health of Central Washington
- Washington State Medical Association
- Washington State Psychological Association

The following individuals and organizations provided comments on the first stakeholder draft:

- Dr. Robert Parker
- Advanced Registered Nurse Practitioners United, Washington State
- Association of Washington Healthcare Plans
- Cambia
- Department of Labor and Industries
- Family Care Network
- Home Care Association of Washington
- Group Health Cooperative
- Molina Healthcare
- National Decision Support Company
- Northwest Health Law Advocates
- Pathology Laboratory Consortium
- Physical Therapy Association of Washington
- The Polyclinic
- Providence Health & Services
- Premera
- UW Medicine
- Virginia Mason

- Washington Ambulance Association
- Washington East Asian Medicine Association
- Washington Healthcare Forum and OneHealthPort
- Washington State Chiropractic Association
- Washington State Massage Therapy Association
- Washington State Medical Association
- Washington State Hospital Association
- Washington State Hospice and Palliative Care Organization
- Washington State Podiatric Medical Association
- Washington State Dental Association
- Washington Speech-Language-Hearing Association

The following organizations submitted comments on the second stakeholder draft:

- Aetna
- American Cancer Society Cancer Action Network
- American College of Radiology and Washington State Radiological Society
- American Massage Therapy Association
- Association of Washington Healthcare Plans
- Cambia
- Coordinated Care
- Express Scripts
- Home Care Association of Washington
- Molina
- National Decision Support Company
- OneHealthPort's pre-authorization work group
- Path Consortium
- Physical Therapy of Washington
- Premera
- Providence Health & Services
- Seattle Cancer Care Alliance
- University of Washington Medicine

- Washington Speech-Language-Hearing Association
- Washington State Hospital Association
- Washington State Medical Association
- Washington State Podiatric Medical Association

The following organizations submitted comments on the second stakeholder draft:

- American College of Cardiology
- American Massage Therapy Association
- Arthritis Foundation
- Association of Washington Healthcare Plans
- Coordinated Care
- Group Health
- J. Hamilton Licht
- Interlake Psychiatric Associates
- James Rotchford
- Kaiser
- Nancy Pfeil
- Janelle Tiegs
- Physical Therapy Association of Washington
- Premera
- Providence Health & Services
- Washington State Psychological Association
- Si Employee Benefits
- Swedish Epilepsy Center
- UnitedHealthcare Insurance Company and United Healthcare of Washington, Inc.
- Virginia Mason
- Washington State Ambulance Association
- Washington State East Asian Medicine Association
- Washington State Medical Association
- Washington Podiatric Medical Association
- Washington State Chiropractic Association

- Washington State Hospital Association
- American Cancer Society Cancer Action Network, American Congress of Obstetricians and Gynecologists, Benton Franklin County Medical Society, ConnecT1D, Grays Harbor County Medical Society, Medical Group Management Association-Washington, National Alliance on Mental Illness-Washington State, National Multiple Sclerosis Society-Greater Northwest Chapter, Snohomish County Medical Society, Thurston Mason County Medical Society, Washington Academy of Eye Physicians and Surgeons, Washington Rheumatology Alliance, Washington Society of Plastic Surgeons, Washington State Medical Association, Washington State Medical Directors Association, Washington State Obstetrics Association, Washington State Orthopedic Association, and Washington State Society of Anesthesiologists

Comment	Response
Effective date	
Stakeholders expressed concern regarding possible effective dates for the online portion of the rule. Some shared that they can meet the January 1, 2018 deadline while others indicated they needed more time (one additional year or more) for compliance.	The Commissioner provided additional time for affected parties to reach compliance with the online requirements, but maintained a shorter implementation timeframe for the other requirements.
Definitions - WAC 284-43-0160	
Stakeholders asked to define prior authorization as broadly as possible.	The Commissioner defined prior authorization to reflect current practices in the industry.
A stakeholder asked to define "utilization review organizations."	The Commissioner respectfully declines. The rule does not address utilization review organizations therefore a definition was not required.
Stakeholders asked what is the basis for including a new type of prior authorization and deleting the "urgent" type of utilization management. This may conflict with references in other parts of Chapter 284-43 WAC.	The "urgent" type is no longer need because prior authorizations are not covered under WAC 284-43-2000 under the new rules. There are no known conflicts with other parts of Chapter 284-43 WAC.
Stakeholder asked to define urgent circumstances.	A definition is not necessary as the rule provides clarification about the distinctions between circumstances that necessitate different timeframes for prior authorization.

Stakeholders asked to clarify what is meant by "in relation to the applicable health plan" in the definition of prior authorization.	The phrase is used to describe a benefit that will be covered by a consumer's policy, subject to any restrictions placed on it by a carrier. Prior authorization requirements are unique to particular health plans. Providers must be able to determine the necessary information for a particular patient based on their health plan.
Stakeholders asked to expand the list of circumstances where a request for expedited review must be honored.	The Commissioner believes the definition is sufficient to cover appropriate situations.
Stakeholders both expressed support and opposition to an immediate prior authorization request that would allow for a quick turnaround when prior authorization is needed.	The Commissioner proposed this concept but decided against its adoption after stakeholders expressed concern that it was not feasible. Instead, stakeholders urged for retrospective review and the Commissioner obliged.
Stakeholders asked that pre-service requirements be included in a pre-determination notice.	The Commissioner agreed that this was necessary. Changes were made to clarify pre-determination notice requirements.
A stakeholder asked to define pre-service requirements.	The Commissioner agreed and included a definition.
Stakeholders asked to clarify the distinction between a required prior authorization and voluntary pre-determination notice and require all carriers to allow a pre-determination request. There was also concern that using the term "mandatory" infers that prior authorization is required for all services.	The Commissioner agreed that these terms needed to be distinguished from each other and added appropriate language to make the distinction. However, "mandatory" does not mean that prior authorization must be placed on all services; it means that if a carrier chooses to require prior authorization, a provider must request it in order to get paid. Furthermore, the Commissioner declines to require that all carriers allow a pre-determination notice. If carriers do allow pre-determination, certain requirements must be followed.
A stakeholder asked to add "A predetermination request is not a prerequisite to a request for prior authorization" to the definition of predetermination request.	The Commissioner believes the language is clear enough as written. Adding the requested language does not change the definition. Furthermore, a voluntary step cannot be required for a mandatory step.
A stakeholder asked to please eliminate the term "sufficient" as it adds uncertainty.	Changes were made to eliminate the term "sufficient."
A stakeholder stated that prior authorization can also tie to clinical requirements for place of service and that should be inserted into the definition.	Prior authorization is a screening mechanism that is distinct from the screening mechanism used to meet other pre-service requirements, which include the place of service.

A stakeholder stated that in the definition of prior authorization, "appropriateness, level of care, and effectiveness" seem to be components of medical necessity and are thus duplicative. They asked to delete these terms.	Medical necessity applies to health plans. For other types of plans, other standards apply, hence the need for these other terms.
A stakeholder commented that prior authorization is frequently applied to diagnostic procedures where those tests or procedures may be prudent, recommended and standard of care incident to the emergency service for treatment of a covered condition not requiring prior authorization. In such instances, it should also be made clear that the tests or studies prerequisite to the emergency covered service are exempt from prior authorization.	Per RCW 48.43.093, prior authorization cannot be required for emergency services. The Commissioner feels that additional rules specifically regarding the prior authorization of services associated with emergency care are not needed.
A stakeholder expressed concern that the definition of prior authorization is not consistent with RCW 48.43.016.	The Commissioner disagrees. The exemptions to prior authorization in RCW 48.43.016 stand on their own and are not affected by the definitions in this rule.
A clarification was requested to allow ARNPs to request prior authorization.	The Commissioner agrees that all providers should have this ability and made changes to clarify the intent of the rule.
It was requested that consumers have the ability to request prior authorization.	The responsibility for prior authorization is on the provider, not the consumer.
A stakeholder commented that the provider should have the ability to define what is expedited.	The Commissioner agrees that providers should have this discretion and made a clarification to account for this ability.
A stakeholder asked if the definition of prior authorization would apply to consumers who are requesting services from an out-of-network provider that would otherwise be covered from an in-network provider.	Requirements related to participating and non-participating providers are clear throughout the rule. Where "participating" is not referenced specifically in the rule, it is generally understood that it pertains to both participating and non-participating providers.
Numerous comments were made regarding the potential overlap between new regulations and WAC 284-43-2000.	The Commissioner cleaned up WAC 284-43-2000 to reduce this confusion. Conflicting definitions and processes in WAC 284-43-2000 were deleted while other types of utilization management were preserved.
A stakeholder asked to define how the passage of time "could seriously jeopardize" the life, health, or ability to regain maximum function of a covered individual, or include a citation to authority where these terms are defined or explained elsewhere.	The provider has the medical expertise to make these determinations and evaluate the need for a more timely approval within the scope of the law.
A concern was raised that the definitions of prior authorization could be interpreted to include any	The Commissioner disagrees. The definitions are appropriately distinct and clear.

period of time and could be applied to almost any situation.	Clarifications were made where necessary to distinguish between different types of prior authorization.
Stakeholders expressed concern regarding the use of different terms to describe similar or the same concepts.	The Commissioner aims for consistency in terminology and made changes to have consistent terms.
Utilization review - WAC 284-43-2000	
Providers also asked for transparency regarding services that do not require prior authorization, but are subject to a carrier's retrospective medical necessity review.	Other than in extenuating circumstances, post-service review is outside the scope of these rules but is generally covered under WAC 284-43-2000.
A stakeholder asked that there be language in this WAC to clarify that prior authorization is covered under WAC 284-43-2050.	The presence of another section signifies that its requirements are generally unique, though not isolated, from other laws.
Stakeholders asked to clarify or update some of the provisions in WAC 284-43-2000.	Generally, the Commissioner avoided changes to WAC 284-43-2000 because the rule is focused on prior authorization, not utilization review generally. However, changes were made to avoid inconsistencies with the new requirements in WAC 284-43-2050.
A stakeholder asked if the changes meet NCQA or other standards?	NCQA standards are distinct from the OIC regulations.
Stakeholders asked to clarify the timeframes for approval of a concurrent review.	Additional clarity was provided in the final rule.
Scope of rule - WAC 284-43-2050(1)	
A stakeholder asked that dental only plans be included in the scope of the rule.	The Commissioner felt this was a reasonable request and made the change.
Stakeholders asked to clarify the applicability of the rule to carriers vs. plans.	The rule was reviewed and modified to clarify if a section or subsection was applicable to a carrier, plan, or both. Both carriers and plans have unique requirements under this rule.
Documented PA program - WAC 284-43-2050(2)	
Stakeholders expressed a desire for clarity regarding the standards that carriers use to make decisions regarding a prior authorization request.	The Commissioner appreciates these comments and made changes to clarify that evidence based clinical review criteria should be used for reviewing a prior authorization request.
One stakeholder expressed a desire to see that only clinical review criteria developed or endorsed by a national professional medical society or provider-led entity be used by carriers.	The Commissioner declines to restrict clinical review criteria to those of a national professional medical society or provider-led entity. Other sources may produce valid and acceptable criteria.

Providers asked for the prior authorization program description to be available online.	Other requirements already exist regarding the transparency of carrier procedures, including utilization review programs. The program description need not be online.
A stakeholder asked that the clinical review criteria be written, rather than just documented.	The Commissioner agreed and made this change.
A stakeholder expressed concern regarding a carrier's use of "current" clinical review criteria while others asked for providers to know what methods carriers have for updating criteria. Stakeholders also asked that providers be able to submit additional clinical material to carriers when they are reviewing and updating their clinical criteria.	A carrier must keep its clinical review criteria current. Providers do not have the right to know the methods that carriers use to keep the criteria current. Furthermore, carriers are not required to involve providers in their process to update their clinical review criteria.
A stakeholder expressed concern regarding the use of the term "clinical review criteria" and stated that its definition should include criteria that form the basis for the prior authorization care parameters such as frequency and duration allowed.	The term "clinical review criteria" was used throughout this rule because it was previously used in the WAC and defined prior to this rule. The definition was only revised slightly to allow its applicability to non-health plans. Clinical review criteria may also be used by a carrier for post-service review, so the definition should not be specific to prior authorization.
A stakeholder expressed concern that clinical review criteria are not made available to providers.	Sharing of the clinical review criteria is required according to RCW 48.43.016. Restating the statute is not necessary.
A stakeholder expressed a concern that if a carrier requires prior authorization, the carrier is practicing medicine and should have a license to practice in the state.	The licensure of medicine for this purpose is outside the scope of the Commissioner's authority.
Stakeholders asked for clarity regarding the definition of "religious nonmedical treatment" and "religious nonmedical nursing care."	This is a requirement under RCW 48.43.520. The terms are undefined in statute.
Stakeholders expressed support for the requirement that carriers maintain responsibility for the actions of third-party entities in hires to manage benefits.	The Commissioner appreciates these comments and holds carriers responsible for the actions of third-party entities it hires to manage benefits.
Stakeholders asked for an explicit allowance for the use of third-parties to conduct prior authorization.	Clarifications were made to allow such entities to process prior authorization, but carriers are ultimately responsible for prior authorization.
Accreditation - WAC 284-43-2050(3)	
A stakeholder suggested that NCQA and other industry best practices should be considered. Other stakeholders stated that the rule appears to mandate NCQA or other national accreditation, which is costly and unnecessary.	Aligning standards between regulatory bodies and other entities such as NCQA, streamlines standards, provides administrative simplification, and mitigates cost. Based on this concept, the rules require carriers to meet

	standards set forth by accreditation organizations, though not receive the actual accreditation. Both URAC and NCQA currently offer certifications or accreditation in utilization management.
Stakeholders asked that carriers be required to list which national certification standards their programs meet. Otherwise, it's unknown how the Commissioner will verify that these requirements are met.	It's not necessary for carriers to list the standards that they meet. The Commissioner has a number of enforcement methods to determine compliance with the law.
Some stakeholders asked that the Commissioner defer to NCQA or URAC accreditation as prima facie demonstration that an issuer has a PA program that meets the OIC's requirements.	The Commissioner declines to accept accreditation as proof that a carrier meets the requirements of the law. However, additional clarity was offered to allow carriers to meet a variety of standards from accreditation organizations.
Stakeholders expressed a desire for prior authorization reviewers to be peers and board certified in the field for which they are reviewing. They also asked for clarity regarding the requirement that staff be "properly qualified, trained, supervised."	RCW 48.43.016 has requirements for reviewers. The rule is clear in its requirements that "a health care provider with whom a health carrier consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration, in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service." Additional clarity is not needed regarding the requirement that staff be properly qualified, trained, and supervised.
Online process - WAC 284-43-2050 (4) & (5)	
Stakeholders generally expressed a variety of perspectives regarding online tools to process prior authorization. Providers asked that they have access to enough information online that they can find out exactly what is needed in order for them to be paid for any given service for any given patient, including pre-service requirements. Carriers advocated for flexibility in putting information online, while providers asked for consistency. Still others supported particular functionality for online tools. Commenters also expressed a desire to move beyond phone and fax by instead developing data exchange standards.	The Commissioner carefully considered all the comments from stakeholders regarding online tools and determined that online tools can significantly improve the prior authorization process if designed properly. Carriers have been given flexibility to design a system (or systems) that meets certain requirements necessary for provider functionality.

Stakeholders asked for clarity regarding the requirements for an online system, specifically whether a single unified system is necessary rather than a website that may require providers to go to several places to get the needed information.	The rule includes standards that a carrier's website must follow. A single unified system is not required to comply with the rule..
Stakeholders asked that the use of appropriate use criteria accessed through electronic clinical decision support tools be a permissible form of prior authorization.	There are multiple methods a provider can use to request a prior authorization from a carrier, including electronic data exchange. This rule requires carriers to allow online submission, though they can also offer other processing methods.
Stakeholders expressed opposition to the option for providers and carriers to agree to an alternative to an online system.	The Commissioner agreed to delete this option.
Providers requested a single portal to request prior authorization, while carriers expressed opposition to requirements for submission of their clinical criteria to a common website.,	A common website is outside the scope of this rule.
Carriers expressed concern that licensing agreements with certain vendors prevents them from posting proprietary information online. They asked for exceptions if the criteria are proprietary or would require additional costs.	RCW 48.43.016 requires that all prior authorization criteria be posted online. Access to prior authorization criteria can be restricted to only eligible parties via a password protect website but there are no exceptions for proprietary criteria. The prior authorization criteria can also be limited to the service in question.
Providers expressed concern that they aren't aware of the criteria that services must meet in order to receive a prior authorization.	The Commissioner is requiring that all carriers disclose pre-service requirements to providers online as well as prior authorization criteria.
A provider group expressed concern that the exact service being delivered may change slightly from the one that is being approved.	The Commissioner is requiring that a carrier's prior authorization requirements be placed online but allowances cannot be made for providers changing the requested service.
It was requested that all individuals, including out-of-network providers have access to written clinical review criteria and related information, not just providers. If the request is for an out-of-network provider, the website should indicate what, if any, additional steps should be taken to obtain out-of-network prior authorization.	Only participating providers and facilities must be granted access to the clinical review criteria. Out-of-network providers must be able to request a prior authorization, but do not have the same rights as participating providers.
Stakeholders asked if electronic notice is sufficient to comply with the requirement for "written notice." Allowing electronic notice was recommended. It was also asked if an on-screen	Written notice includes electronic notice. It means a method that is transparent and auditable. The purpose of the requirement is to ensure transparency to providers. Carriers must provide acknowledgement that the message

notification is sufficient or does the rule require a "push" message.	has been transmitted as is provided for in the contract. The requirement prescribes the elements of the process, but not the process itself.
Carriers expressed concern that some issuers (such as vision/dental) do not have a significant number of services that require prior authorization and thus the cost of building an online system is not justifiable. Carriers also stated that compliance might cost $1 million or more.	The Commissioner has found that the benefits of a standard online process outweigh the costs. When a plan chooses to have prior authorization requirements, it must have appropriate systems in place to facilitate it.
Carriers expressed opposition to the online system because providers do not use them. They also said that carriers may abandon fax based systems if the rule were to proceed.	Online systems are necessary to reduce errors and improve the quality of the prior authorization process. Fax based systems are largely not affected by the rule, except to the extent that they do not meet the new requirements.
Carriers asked that carriers be allowed to require providers to use the online tools.	Carriers have the right to create a provider network that meets their criteria, provided that unlawful discrimination is not used in creating the network and that they have a complete network.
Stakeholders asked for additional guidance regarding expectations for an "interactive" online system. Others expressed support for the Commissioner's desire for carriers to have significant flexibility in designing an online prior authorization system that would meet their needs.	The Commissioner realized that the term "interactive" was unnecessary and removed it from the regulation. Flexibility for carriers in meeting standards is important to the Commissioner.
Stakeholders asked for clarification to more clearly understand the requirement that a provider be able to complete a prior authorization request online. Once clarified, they expressed support for the online system to "complete" rather than just "facilitate" a prior authorization request.	The Commissioner made changes to clarify the requirements and appreciates the support for this change.
Providers expressed concern that they are sometimes told that prior authorization is not required, when in reality it means that the service is not covered. They also asked that carriers clearly indicate if the denial is because a service is experimental or investigational (or otherwise not covered).	The Commissioner requires a clear rationale for a denial. A denial must include the reason for the denial so that the provider understands why the prior authorization was denied.
A stakeholder asked that enrollees be allowed to access a carrier's online prior authorization system.	Prior authorization is the responsibility of the provider. Enrollees have no need to access the online system.
A stakeholder asked that online systems be required to have a minimum 99% up time.	The Commissioner recognizes that online systems have technical requirements but

	providers must be able to have a means of submitting a prior authorization at all times.
A stakeholder expressed concern that the online requirement for pharmacy benefits could make things more challenging.	With some exceptions, the rules do not apply to prescription drugs.
Providers asked for additional specificity regarding the technical components of an online prior authorization program, including allowances for complete diagnostic descriptions/coding and using best fit ICD-10 or commonly used codes.	This level of specificity is not required for online systems.
Providers asked for the ability to search for specific benefits, formulary, and plan information by patient identification numbers.	A specific means of accessing this information is generally outside the scope of this rule.
A provider asked for additional elements related to the prior authorization process, such as requirements for a case number to be assigned to each prior authorization and a "comments" area in each PA form.	The Commissioner specified certain elements that must be considered during the prior authorization process but did not go into the specificity requested by this stakeholder as each carrier may have slightly different means of processing prior authorization.
Carriers asked how often they would be required to update their online prior authorization systems in order to be considered "current."	It is understood that a small amount of time may pass between the carrier's adoption of a new prior authorization requirement and the online posting of that requirement. However, the updating need not to be in real-time - overnight updating is sufficient.
Integrated delivery systems asked for an exemption for their employees for the online requirements given their unique infrastructure.	The Commissioner thought this was reasonable and added a limited exemption.
Out-of-network providers requesting prior authorization - WAC 284-43-2050(6)	
Carriers expressed concern regarding the requirement that out-of-network providers have the ability to request a prior authorization. Interactions with out-of-network providers are typically done through the enrollee so it should be a business decision by the carrier.	Carriers that offer a product with out of network benefits requiring prior authorization must be prepared to allow those providers to request a prior authorization. Enrollees are to be taken out of the prior authorization process.
Providers expressed a desire for out of network providers to have access to the same methods for requesting prior authorization as in-network providers, such as online access to pre-service requirements.	Out-of-network providers do not have the same rights as in-network providers, but still need some ability to request a prior authorization.
Allowance for prior authorization request at any time - WAC 284-43-2050(7)	
Carriers expressed concern that around the clock availability to review prior authorizations was unnecessary given that emergency care does not require prior authorization. Alternatively, providers	Changes were made to clarify that carriers must have a way to accept a prior authorization request at any time, but they do not need to

expressed a desire to be able to submit claims online or by fax around the clock. Clarifications were also requested regarding exact requirement.	start reviewing the process until their regular business hours.
Stakeholders also asked for clarification regarding the correlation between the ability to submit a prior authorization and the provisions for the turnaround times.	A provider must be able to submit a prior authorization request at any time. However, it is acceptable for a carrier to not start the review of the prior authorization request until the start of their normal business hours, provided that the review timeframes are met.
Providers expressed support for the requirement to allow prior authorizations to be submitted at any time. They also acknowledged that a carrier may wait until business hours to begin processing the prior authorization.	The Commissioner appreciates this support.
Documentation and recordkeeping - WAC 284-43-2050(8)	
Providers expressed concern that carriers (or their designees) have lost the medical records that have been sent to them by providers, so prior authorization is delayed. They expressed support for the requirement to track the information that's been provided to them. They also asked that this information be provided to them upon request.	The Commissioner is instituting record retention requirements, including confirmations to ensure that documents are not lost. However, the Commissioner is not requiring that carriers give providers access to the exact information given to them by the providers as providers should be aware of the documents they submit to the carrier.
Carriers asked how they are expected to comply with the requirement to acknowledge receipt of documents sent to them by providers.	Carriers must take a proactive step affirming that they have received documents sent to them if the provider or facility has requested it.
Stakeholders asked for copies of the information that they have submitted to a carrier.	While carriers have obligations to confirm receipt of documents submitted to them, providers have a responsibility to record the information they provided to carriers.
A stakeholder asked that carriers be required to inform providers how to request the receipt of documentation.	Providers have an obligation to understand their rights. Carriers are not required to continually remind providers how to request receipt of documentation.
Stakeholders shared that requiring receipt of all documentation and phone calls is burdensome and goes beyond the best practice. Phone calls should be allowed to address questions or concerns but information should only be submitted electronically and the website should provide acknowledgement.	Providing confirmation of receipt of information is reasonable giving the importance of the information transmission in ensuring consumers are able to access benefits.
Carriers expressed a support for alternative language that would require them to retain all medical records submitted by a provider in	The Commissioner clarified recordkeeping requirements so as not require excessive recordkeeping.

support of a prior authorization request until the process of determining the prior authorization is concluded.	
Timeframe policies - WAC 284-43-2050(9)	
Carriers should clearly specify what information is missing from the requests at the time of notification.	Carriers will be required to notify providers of what information is missing.
A carrier asked how it was expected to tell providers when more information is needed. A provider also asked for a requirement that carriers call a provider in addition to sending a letter or faxed request.	The rules do not establish the method by which the communication must take place. Providers may negotiate with carriers for notification by a certain method.
Stakeholders expressed concern regarding the relationship between the requirement for carriers to have policies that assure timely review of prior authorization requests and the actual timeframes in the rule.	The requirement for carriers to have policies to assure timely review of prior authorization requests does not allow carriers to have more leeway in determining what's a proper timeframe than is required by the rule.
Timeframes - WAC 284-43-2050(10)	
Significant comments were provided about the timeframes required for carriers to respond to a prior authorization request. Some said it is problematic for carriers and providers to respond within a set number of days when they are closed for weekends or holidays. Others requested shorter or alternative timeframes or other clarifications such as the definition of 24 hours of "calendar" day. Stakeholders also asked for allowances that would consider timeframes in which to make changes to an initial request or deem requests approved if timeframes aren't met. Other stakeholders expressed support for the industry best practices to be adopted into rule.	The Commissioner considered all these comments when determining the appropriate timeframes for carrier review of a prior authorization request. Clarifications were provided to specify exact requirements that minimize alternative interpretations of the rule. Industry best practices were reviewed to determine proper regulations.
Please replace the term "review" with "authorization," "decision," or "determination."	The change was made.
A stakeholder expressed support for carriers to comply with the regulatory deadlines for submission and not their own issuer-specific guidelines.	These timeframes will be required by law.
Stakeholders expressed support for alternative methods for reducing wait times, such as automated authorizations in real time for certain services, exempting providers who use certified appropriate use criteria from prior authorization, automatic approval for laboratory services and an automatic approval when timeframes aren't met.	The Commissioner has determined that these alternatives are not sufficient as they infringe upon a carrier's ability to manage utilization.

General ground rules - WAC 284-43-2050 (11)	
Stakeholders suggested that the requirement for carriers to accept any "reasonably reliable source that will assist in the authorization process" be clarified.	The provision was clarified to be limited to evidence-based information from a provider or facility.
A stakeholder expressed support for the language that limits issuers to request only the specific information need to make a determination.	Thank you.
Stakeholders requested clarification regarding the routine collection of diagnosis and procedure codes. Some asked that carriers allow for a range of codes.	Clarifications were made to specify that diagnosis and procedure codes can be required for a prior authorization.
Stakeholders expressed concern that the routine collection of medical records is in fact necessary for an appropriate medical determination. They also asked if the language applies to concurrent reviews.	The language was re-worded to address this concern, though it was does not encompass inpatient concurrent reviews.
Carriers should only be allowed to request a patient's medical records when there is difficulty in determining the appropriateness of the health care service.	The Commissioner has set a reasonable standard regarding the requesting of medical records during a prior authorization review.
Stakeholders expressed concern regarding the requirement that review determinations be based on the medical information obtained by the carrier at the time of review.	Carriers cannot make decisions regarding a prior authorization based on information that the provider did not have at the time of the request. Medical records may be a source of information for the carrier's decision.
Providers expressed concern that third party administrators are not always in sync with the carriers who hire them. They also expressed other concerns regarding the practices of third party administrators.	The Commissioner has made it clear that carriers are responsible for the behavior of third party administrators. In case of disputes, the carrier's requirements are primary. Carriers must require that any third party administrators use the medical necessity definitions used by the carriers.
Stakeholders thought that the (d) and (a) of this section were contradictory.	There is no contradiction between these two provisions. Medical records may need to be reviewed by a carrier but they must also accept any evidence-based information from a provider.
Notifications and denials - WAC 284-43-2050 (12)	
A stakeholder expressed support for the requirement of a written notice of a decision.	The Commissioner appreciates this comment.
A stakeholder asked to state the requirement for carriers to provide the reason for a denial in a neutral manner.	The Commissioner agreed and re-worded the requirement.

Providers desired some sort of documentation that would provide proof of an insurer approving a prior authorization request. Another stakeholder noted that NCQA requires notification for denials only.	The Commissioner is requiring written notice of a prior authorization approval.
A stakeholder expressed a desire to not require written notification when prior authorization is submitted electronically.	Providers need to have proof that a prior authorization was approved. It can occur in a variety of forms, though must be auditable.
Stakeholders asked for clarification regarding the decision notice that must be communicated to providers, facilities, and enrollees after a prior authorization decision has been made by the carrier. It was noted that adverse benefit determination regulations address this topic as well.	The notification to the enrollee does not need to duplicate that which would be required under other laws (i.e. adverse benefit determination laws).
It was asked if the referring/ordering provider or the approved/denied provider should be given notice of the approval or denial.	The regulations are silent in this regard.
A stakeholder asked that both the enrollee and provider receive notice of a prior authorization decision.	The Commissioner agrees.
Stakeholders provided numerous comments regarding ways to streamline the denial process. Some asked for the opportunity to discuss medical necessity prior to a denial while others asked for a standard appeal process, with specific information regarding the reason for the denial be given to the provider. The provider and enrollee should have the ability to challenge the prior authorization.	Generally, the appeals process is well-established in regulation and through provider contracts. However, clarity has been provided in the rule to ensure that providers are aware of reasons for a denial and they are aware of appeal rights. Providers can file an appeal of a prior authorization denial without requiring written permission of the consumer.
Stakeholders stated that only denials should be communicated in writing to providers. Approvals are often done over the phone (or online) and these practices should be allowed to continue.	Clarity has been provided to make it clear that approvals can occur over the phone, but a written notice must also be provided.
Providers expressed concern that carriers were withdrawing prior authorization approvals and requested a prohibition on retroactive denials.	RCW 48.43.525 prohibits carriers from retrospectively denying a prior authorization that had already been granted.
A stakeholder asked that any individual with decision making authority over prior authorization be licensed to practice medicine in Washington. In addition, reviews should be conducted during the business hours where the patient is located, not where the carrier is located.	The Commissioner declines to require prior authorization decision-makers to be licensed in the state of Washington. Certain standards for reviewers are appropriate but should consider the national implications of health care delivery.
Providers expressed concern regarding the need to interact directly with a carrier's medical director for a peer-to-peer consult. Stakeholders expressed a	The Commissioner established that a contact phone number be included with a denial so that a provider can reach out to the individual.

desire to streamline this interaction while protecting the privacy of the reviewer.	
Stakeholders asked that the name and credentials of the individual authorizing the decision be made available to providers. Alternatively, other stakeholders opposed releasing the name of the authorizing individual.	A denial need only include the department and credentials of the reviewer, plus contact information. Additional information is unnecessary.
Require the individuals reviewing a prior authorization to be licensed practitioners in the state as well as the same medical specialty being reviewed.	This has already been addressed in RCW 48.43.016.
A carrier expressed support for their ability to deny insufficiently documented requests based on the initial submissions only on the basis that the request has not been adequately supported. The exception would be minor, de minimis deficiencies which can be readily cured.	Carriers must follow the requirements for responding to a prior authorization request. A denial would result in the opportunity for appeal.
Providers asked that carriers clearly explain their rationale for a whole or partial denial of services. They asked that carriers use plain talk in their communications.	Denials must state the reason for the denial, but mandating plain talk goes beyond the scope of this rule.
Stakeholders expressed concern regarding language used in an earlier draft regarding the requirement for a carrier to provide information to providers about a denial. It was stated that the language was duplicative and accusatory.	A change was made to simplify this language.
A stakeholder asked that two day certified mail be required when electronic communication is not available for providers who do not use fax or email.	The rule does not prescribe the method of communication, as carriers have a number of ways to communicate with providers.
It was asked that the appeal rights notice include the address, website, phone, and fax number of the appeals department.	Specific information that must be communicated regarding appeals is dealt with by other laws and outside the scope of this rule.
Prior authorization for out-of-network providers - WAC 284-43-2050(13)	
Providers have asked that the consumer be told if they have received prior authorization and are seeing a provider who is out of network.	The Commissioner is requiring carriers to alert consumers to the financial ramifications of seeing an out-of-network provider if they have received prior authorization for that provider.
Requiring notification of the potential for an out-of-network prior authorization does not take into account the possibility that a facility/provider may not yet be known. Others requested additional clarification regarding the provision or expressed	Clarification has been added to make it clear that consumers need to be aware of the potential for higher costs if they see out-of-network providers.

concern that the language could complicate the process.	
Carriers expressed concern regarding the requirement for a carrier to notify consumers of the implications of receiving services out of network. The exact cost may not be known because it depends on a variety of factors. They urged that this requirement be dropped because it would require additional IT costs to connect prior authorization systems with claims adjudication systems.	The exact cost need not be communicated to consumers, but consumers need to be made aware of the financial implications for seeing a provider outside of their network. Consumers are at a disadvantage without this information.
Provider appeals - WAC 284-43-2050(14)	
Each carrier should be required to have an appeal process when a provider disagrees with the decision.	This has been included within the rule. Providers can file an appeal even without written approval of consumer.
Carriers expressed concern regarding the effects of this subsection.	The results of a prior authorization decision are not final and there must be an opportunity for providers to ask carriers to re-consider their decision.
Expiration date - WAC 284-43-2050(15)	
Stakeholders expressed a desire to allow prior authorizations to remain in place for up to 12 months (or even indefinitely) for ongoing prescriptions.	Carriers generally allow prior authorization for the length of the refill or contract term, but a compelling case has not been made why this should be mandated. There are legitimate clinical reasons why a prescription might be limited.
Stakeholders asked for longer expiration periods to allow for additional time to see specialists.	A 45 day floor is reasonable. Carriers may offer additional time if they desired.
Stakeholders asked if a carrier could revoke prior authorization if the enrollee is no longer eligible for coverage.	Eligibility is defined by the terms of a consumer's policy. If a consumer receives prior authorization for a service, the consumer's eligibility can be considered when reimbursing for a service that receives prior authorization. The 45 day expiration period does not supersede enrollment and eligibility laws.
A stakeholder asked to allow a shorter expiration period at the request of the provider.	A 45 day floor is reasonable.
Stakeholders expressed concern regarding the length of the expiration period.	A 45 day floor is reasonable for consumers to be able to access benefits promised to them under the terms of their contract.
Carriers asked if they must continue to be responsible for a service is the enrollee moves to another carrier.	Except where otherwise noted in the rule, the expiration period is only applicable during a consumer's enrollment in the plan.

Market withdrawal - WAC 284-43-2050(16)	
A stakeholder requested that carriers recognize the prior authorization for services that were obtained prior to enrollment. Additional support was expressed for this provision.	The Commissioner considered this request and thought it was reasonable in the limited circumstances of a health plan withdrawing from the market. In other circumstances where a consumer voluntarily changes plans, they are subject to a new carrier's prior authorization program.
Carriers expressed opposition to the requirement that they be responsible for another carrier's prior authorization approval. They provided alternatives to the solution proposed.	The Commissioner believes that the requirement is reasonable and limited its applicability based on feedback from stakeholders.
A stakeholder requested that consumers be allowed a transition fill when a patient switches plans or a formulary changes.	This is outside the scope of the rule.
Stakeholders asked for clarity regarding the instances in which this provision would apply.	Clarity was provided that limited the provision to a very particular circumstance.
Carriers asked that this provision not apply when consumers enrollment lapses between plans.	This provision is only applicable during continuous enrollment, though other eligibility laws apply.
Facility-to-facility transports - WAC 284-43-2050(17)	
Ambulance providers stated that requiring an ambulance provider to obtain a prior authorization is unfair and should be requested by medical staff caring for the patient at that time. Most requests for non-emergent single ambulance transports occur with little or no notice so its difficult to obtain prior authorization within the timeframes required.	The Commissioner recognizes that facility-to-facility transports have unique constraints that should allow for a retrospective review. Referring providers are responsible for requesting the prior authorization.
Stakeholders asked to clarify that this section applies to non-emergent ambulance transport.	The intent of this section is clear as it applies to transportation between facilities that may require prior authorization.
Requesting prior authorization in advance of seeing patient - WAC 284-43-2050(18)	
Stakeholders expressed concern regarding the appropriateness of providers requesting a prior authorization in advance of seeing a patient. Some stated that it interferes with product design while others said that it is goes against the standard of care that require a provider to physically see a patient before a service can be recommended. Stakeholders asked for clarification regarding this provision, including its purpose. Some asked to extend its utility to including imaging, while others asked that it first require a referral from a PCP and/or at the request of the enrollee. Others asked	Numerous changes were made to clarify the intent of the provision, which was to prevent consumers from having to travel long distances repeatedly in order to allow time for a provider to make a prior authorization request. Instead, the provider should request prior authorization prior to seeing the consumer so that the service can be delivered at the appointment. Given its purpose, a limited scope is reasonable. Carriers can place lawful requirements on this procedure to allow reasonable utilization.

that it be extended to any provider, not just specialists.	
Stakeholders expressed support for this provision.	
Predetermination notices - WAC 284-43-2050(19)	
A stakeholder asked to clarify the difference between prior authorization and pre-determination notices.	Additional requirements were added to ensure that a clear boundary exists between the distinct processes of prior authorization and pre-determination.
Please clarify the requirement related to pre-determination notices.	Some plans allow consumers to make a non-binding pre-determination request. Plans are not required to offer this service, but when they do, it must be available to enrollees and providers.
Extenuating circumstances - WAC 284-43-2060	
Many stakeholders requested a retrospective review process for cases where services need to be provided before authorizations could be obtained. They also requested a standardized process, expanded time frames for consideration, and criteria for consideration of extenuating circumstances.	The Commissioner also believes it is necessary to allow prior authorizations to be granted retrospectively under limited situations and included a provision requiring such a policy.
Please allow an expedited prior authorization for referrals to home care or transfers to other setting.	The Commissioner is allowing a prior authorization for institutional or home health care to be considered as an extenuating circumstance.
When considering the scope of the extenuating circumstance provision, please consider the unintended consequences for the patient. If the provider relies on a retrospective review, the consumer is at risk if the claim is later denied by the carrier.	The Commissioner appreciates these comments and has tried to balance competing goals of flexibility for the provider and consumer protection.
Carriers expressed concern that the situations included in this section are too broad and preferred that specific terms used by OneHealthPort be included instead.	

Stakeholders expressed a desire to see a number of particular circumstances be included as an extenuating circumstance, including patients who travel long distances, an unforeseen circumstance that requires the provider to modify the procedure, home health services, incorrect insurance information has been presented to the provider by the enrollee, and instances where an issuer can't complete its review as a result of unavailability outside business hours.	The Commissioner carefully considered the various circumstances that should be considered as an extenuating circumstance. The Commissioner tried to balance a legitimate need for retrospective review with a carrier's legitimate need to manage utilization.
Carriers asserted that under the proposed language, carriers are not permitted to assess the validity of the provider's assertion that they didn't have time to submit the prior authorization request. They asked to still be able to control provider/facility abuse.	Carriers are allowed to request documentation from the provider to support their assertion that insufficient time existed to request a prior authorization. Carriers may make other reasonable restrictions on providers who are requesting an extenuating circumstance.
Stakeholders asked to clarify the early version of the language describing extenuating circumstances section as its effect was unclear.	The Commissioner made changes to the rule to clarify the intent.
General comments on prior auth rules	
Several stakeholders requested that limits be placed on the prior authorization of health care services as they saw prior authorization as a barrier to good medical care. Some suggested a financial standard be met before prior authorization be allowed, while others suggested a clinical quality standard or involvement by providers. Others suggested the creation of statewide clinical standards or the elimination of prior authorization for low-cost, high value treatments. Another stakeholder requested that providers be exempt for prior authorization if they use appropriate use criteria. Still another stakeholder recommended that carriers be required to demonstrate that any new requirements are needed and would reduce non-medically necessary services. Another suggested that after retrospective audits are conducted on all providers, only those providers exceeding a predefined threshold of utilization should be subject to pre-certification.	The Commissioner declines to significantly limit carriers' use of particular prior authorization standards as prior authorization is a lawful utilization review and cost-control method. Carriers must make prior authorization decisions in accordance with a carrier's medical necessity clinical review criteria.

A stakeholder expressed concern that current carrier prior authorization practices are more related to practitioner behavior and arbitrary constraints rather than clinical patient data. Providers expressed concern that they are only receiving approval for limited services that do not meet patient needs. Prior authorizations should be granted according to clinical circumstances of the patient and supportable clinical rationale or care guidelines.	The rule clearly states that prior authorizations should be made in accordance with a carrier's evidence-based clinical review criteria.
A stakeholder asked that the OIC not add distinct rulemaking for prior authorization and instead recognize that prior authorization is part of overall utilization management practices in WAC 284-43-2000.	The Commissioner believes that distinct rules are needed for prior authorization, distinct from WAC 284-43-2000 because it has the potential to delay access to care.
Some stakeholders expressed a desire for the Commissioner to examine specific complaints from providers with an aim of addressing the concerns rather than establishing new regulations.	The Commissioner has the authority to write rules regarding the prior authorization process. Rules are necessary to protect the rights of consumers as they access covered benefits.
Stakeholders asked for additional information regarding the problems that are believed to exist and how the proposed regulatory changes are intended to fix them.	The Commissioner held several stakeholder meetings to discuss the need for the rule and how the rules will address issues brought forward by stakeholders.
Stakeholders asked that the rules create a more balanced approach that encourages provider submission of well-documented prior authorization requests and provides for more equalized turnaround requirements.	The Commissioner believes that well-document provider submissions are an important aspect of the prior authorization problem and has crafted the rule to encourage such complete submissions.
Stakeholders asked to break the rule into separate subsections for readability, ease of reference, and comprehension.	The rule has been revised for clarity and ease of use per stakeholder request.
Stakeholders expressed concerns regarding the formulary management practices of carriers, including step therapy.	Formularies are outside the scope of this rule.
A provider asked the Commissioner to re-assess existing regulations related to experimental and investigational treatment as well as off-label drugs.	This is outside the scope of this rule.
Commenters expressed support for alternative arrangements to the traditional prior authorization process, such as provider integration of clinical criteria into their care delivery.	Alternative arrangements to prior authorization are outside the scope of this rule.
A provider expressed concern regarding denials from Medicaid managed care organizations.	This is outside the scope of this rule. The Health Care Authority (not the OIC) has control over Medicaid plans.

A provider expressed concern regarding the consistency of information given to their patients by carriers as compared to the information they receive from carriers.	The regulations are meant to eliminate inconsistencies by providing transparency and clear standards.
A provider group raised concern over the coverage of psychological and neuropsychological testing, including whether its covered under a medical benefit or under the mental health benefit.	This is outside the scope of this rule.
A stakeholder expressed concern that authorizations are specific to a provider that initiates the authorization, instead of specific to a patient and their authorized care.	This is outside the scope of this rule.
A stakeholder asked that the state do more to encourage common standards and interoperability with EHRs, including the use of HIPAA standards.	This is outside the scope of this rule.
Numerous stakeholders shared comments regarding a statewide prior authorization portal.	This is outside the scope of the rule.
Numerous provider groups expressed concern regarding the burdensome functionality of a TPA's website.	This is outside the scope of the rule.
A consumer asked that carriers provide a list in advance of all the third-party service providers that they use. The consumer also asked that carriers be required to seek a consumer's prior approval before using a third-party service provider.	This is outside the scope of the rule. Carriers have the right to use third-party administrators though they are responsible for their actions. When a consumer purchases a product, they agree to the terms of the contract that governs product usage.
A provider asked that patients be given the option of paying cash for a prescription and being reimbursed if and when the prior authorization goes through.	Such a provision is already contemplated in state law.
An individual asked that the rule consider requiring carriers to provide consumers with additional information when consumers ask about the process for obtaining a prior authorization. The individual stated that carriers imply that the process to obtain a prior authorization only requires a phone call from the provider when the individual believes that the process is more burdensome than that.	Carriers are required to provide consumers with accurate information about the terms of the consumer's benefits. However, the Commissioner relies on complaints to determine if carriers are not fulfilling their obligation in this regard.
Stakeholders requested clarification regarding the applicability of the rules to prescription drug services.	Clarification was provided to distinguish the rules from pre-existing rules related to prescription drugs in WAC 284-43-2020.
A stakeholder requested that the OIC require data from carriers regarding their prior authorization practices.	The Commissioner already has general authority to request data from carriers regarding prior

	authorization but a compelling need has not been identified.
A stakeholder requested that the Commissioner develop standards to ensure that the rules are followed and carriers are penalized for failure to comply with the requirements.	The Commissioner has established policies and procedures for determining compliance with state law. Creating a unit to proactively review compliance with state law requires resources that we currently do not have.
A stakeholder requested that an insurer be required to demonstrate sufficient network access if they place limitations on specific sites of care. They also asked that there be a mechanism to retrospectively recognize alternative sites of service where access did not exist. Furthermore, prior authorization rules should address inclusive out-of-network benefit level exceptions that are required when the services are not available from an in-network provider.	Issuers must always demonstrate network access. The Commissioner will not require retroactive recognition of alternative sites – issuers need approval for networks that don't meet access standards. Other requests are related to network rules and are outside the scope of these rules.
A stakeholder asked that the rules allow all necessary tests and treatments to be performed by the specialty center if the treatment has been authorized.	The Commissioner declines to make this requirement as some services can be delivered elsewhere.
A stakeholder asked for sub-regulatory guidance when requested to clarify what exactly is required of carriers and providers.	As appropriate, the Commissioner does issue sub-regulatory guidance in the form of TAAs.
A stakeholder asked that pathology and laboratory testing be placed under the prior authorization for the approved medical procedure. They also asked that downstream providers be allowed to request prior authorization for the needed testing.	Providers could negotiate for this ability but otherwise it is outside the scope of the rule.
Providers expressed concern regarding the retroactive denial of covered, medically necessary services. They stated that this also occurs for dental services.	RCW 48.43.525 prohibits the denial of services that had prior authorization. However, it only applies to health plans, which excludes dental-only coverage.
A stakeholder expressed concern regarding unintended consequences for carriers to adopt web requirements when advances in health information exchange may render a web-based process less desirable for both payers and providers.	The Commissioner appreciates this concern, but notes that carriers need to raise the bar in order to streamline prior authorization. The rule may be revisited in the future when technology advances.
A stakeholder asked that carriers be required to note in their explanation of benefits that prior authorization is required before a benefit can be obtained by a consumer.	The consumer's certificate of coverage contains the full requirements related to accessing coverage and is required to be shared with consumers prior to enrollment.

A stakeholder asked that the Commissioner reconvene stakeholders after the rule has gone into effect to determine if further rules are necessary or amendments need to be made.	The Commissioner will monitor the implementation of the rule and consider changes as they are necessary.
Stakeholders asked that the Commissioner reconsider the rules in light of the uncertainty posed by the reforms proposed by Congress.	The Commissioner believes the rules are necessary despite the debates in Congress about the future of the ACA. If Congress passes a new law, the Commissioner reserves the right to consider additional changes.
Numerous comments were provided regarding a requirement shared in an early draft regarding a carrier's obligation to reimburse the cost of medical record duplication. Some stakeholders favored this requirement while others expressed concern regarding its precise requirement.	The original requirement was a restatement of existing law - RCW 70.20.010(37) and WAC 284-08-400. Given concerns about how to define reasonable, the restatement has been taken out of this rule. However, the underlying laws still are in effect.
Many stakeholders expressed concerns regarding carriers suddenly requiring prior authorization for services that weren't subject to prior authorization previously. Some suggested that changes be limited to contracting cycles, with limited exceptions. Still others suggested that changes be subject to the same or broader notification requirements as other contract changes or be considered as material changes.	The Commissioner recognizes that changing prior authorization requirements pose a challenge for providers. Per WAC 284-170-421 (5), utilization review (and thus prior authorization) needs to be in provider contracts and is subject to relevant laws. Changes that affect provider or facility compensation or health care service delivery must be given 60 days prior notice (WAC 284-170-421 (6)).
Providers expressed support for the proposed language that clarifies that the imposition of new prior authorization requirements is subject to notification requirements governing changes to provider contracts.	The Commissioner appreciates the support. However, the language was deleted as the proposed clarity regarding existing law is unnecessary. The requirement for prior authorization to be included in provider contracts is set forth and enforced per WAC 284-170-421 (5).
Carriers expressed their opposition to including prior authorization in provider contracts. They believed it would require significant contract amendments that could disrupt provider contracting. Carriers suggested alternatives, including a transparent process of updating prior authorization processes (with prior notification) and online posting. They also recommended that only limited prior authorization related information be transmitted via provider contracts with additional information posted online or included in provider handbooks.	Per WAC 284-170-421, prior authorization programs must be included in a provider or facility contract. The contract must give providers 60 day prior notice before a carrier makes any changes to its prior authorization program, including adding new prior authorization requirements to services or changes to the clinical criteria used to approve prior authorization. The contract must also include the method or methods the carrier uses to accept prior authorization requests and the method for the provider or facility to appeal a prior authorization denial.

Providers asked if the changes to provider contracts would be material changes.	The OIC cannot address hypothetical questions of this nature in the CES. It is unclear what types of changes may be made by the parties in the future. That being said, the law defines, for third party payors, the term "material change" in RCW 48.39.005.
Carriers asked for the timeframe for their provider contracts to be in compliance with requirements.	All contracts must comply on or after January 1, 2018.

Implementation plan

Implementation and enforcement of the rule

The OIC intends to implement and enforce the rule through the Market Conduct Oversight Unit, which is part of the Company Supervision Division. Using existing resources, OIC staff will continue to work with carriers, providers, and interested parties in complying with the requirements of these rules.

As indicated in the CR-103, the rule has a staggered effective date. The new definitions are effective 31 days after adoption. The bulk of the rule takes effect January 1, 2018, though the online requirements in WAC 284-43-2050 (4) & (5) are not effective until November 1, 2019. The OIC expects carriers to comply with the existing requirement to include provisions of prior authorization in provider contracts no later than January 1, 2018.

How the agency will inform and educate affected persons about the rule

After the agency files the permanent rule and adopts it with the Office of the Code Reviser:

- Policy staff will distribute copies of the final rule and the Concise Explanatory Statement (CES) to all interested parties by posting to its standard rule making listserv and emailing stakeholder participants.
- The Rules Coordinator will post the CR-103 documents on the Office of Insurance Commissioner's website.

OIC staff will address questions as follows:

Type of Inquiry	Division
Consumer assistance	**Consumer Protection Division**
Rule content	**Policy and Legislative Affairs**
Authority for rules	**Policy and Legislative Affairs**
Enforcement of rule	**Legal Division**
Market Compliance	**Company Supervision**

How the agency intends to promote and assist voluntary compliance for this rule

The steps listed under implementation will inform and educate affected persons on the changes and help promote voluntary compliance.

How the agency intends to evaluate whether the rule achieves the purpose for which it was adopted

The OIC will work closely with carriers, providers, and other interested parties to evaluate the effectiveness of the rule as well as monitor consumer complaints and to monitor plans for non-compliance.

Appendix A – Hearing Summary

Summarizing Memorandum

To: **Mike Kreidler, Insurance Commissioner**

From: **Jim Freeburg, presiding official for rule hearing**

Matter: **Rule 2016-19**

Topic: **Prior authorization**

This memorandum summarizes the hearing on the above-named rulemaking, which was held on January 4, 2017 at 11:00 a.m. in Tumwater. I presided over this hearing in your place.

The hearing began at 11:01 a.m.

In attendance but did not testify:

- Barb Prentice, UW Medicine
- Beth Berendt, Berendt and Associates
- Ben Beasley, Coordinated Care
- Jackie Barry, Physical Therapy Association of Washington
- Meg Jones, United Healthcare

In attendance and testified:

- Bob Berschauer, Washington Ambulance Association
- Jeb Shepard, Washington State Medical Association
- Waltraut Lehman, Premera
- Gail McGaffick, Washington State Podiatric Medical Association
- Leslie Emerick, WA East Asian Medicine Association

Testimony content:

- Bob Berschauer shared the impact of prior authorizations on ambulance providers and the unique circumstances they face because they do not see the patient prior to picking them up.
- Jeb Shepard thanked the Commissioner for the rules as prior authorization is seen as the primary administrative burden. He urged the adoption of the rule, including consideration of WSMA's written comments. He also asked that the OIC provide sub-regulatory guidance after

the rule is finalized to provide examples of extenuating circumstances and review the effects of the rule after adoption.

- Waltraut Lehman summarized some key points from Premera's written comments, regarding the implications of the rule as proposed. She urged additional work to minimize the burden of the rule and consider the potential impacts of changes at the federal level. She expressed concern over the extensive system requirements, consumer protections in the event of market withdrawal, and extenuating circumstances.
- Gail McGaffick expressed strong support for the rule and thanked the rule team for their hard work and opportunity to learn from other stakeholders. She also shared her thoughts on provider complaints and extenuating circumstances.
- Leslie Emerick shared two examples of where she believes additional clarity is necessary. She'd like to see additional access for out-of-network providers and the ability of providers to see documentation they have given to carriers.

The hearing was adjourned.

SIGNED this 4th day of January, 2017

Jim Freeburg, Presiding Official