

Prior authorization processes rule (R 2016-19)

Stakeholder draft released on: July 15, 2016

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Comment deadline: August 17, 2016

WAC 284-43-0160 (New definitions)

"Prior authorization" is a process that an issuer uses to determine if a health care service is a covered benefit and meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan. Prior authorization occurs before the service is rendered. For purposes of this rule, any term used by an issuer to describe this process is prior authorization. For example, prior authorization has also been referred to as "pre-authorization," "preauthorization," or "precertification."

"Standard prior authorization 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

"Expedited prior authorization 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.

Subchapter D - Utilization Review and Prior Authorization

WAC 284-43-2050 (New Section)

(1) Issuers must make sufficient information available online to participating providers or as mutually agreed to by all parties so that, prior to delivering a service, providers will be able to determine whether a service is subject to prior authorization.

(a) When a provider makes a request for the prior authorization, the notice must be clear and explain if it is approved or denied and the justification for the decision, for example the prior authorization is denied because the service is a non-covered benefit. Written notice of the decision must be communicated to the provider and enrollee. The decision must include the name and credentials of the individual who had the authorizing authority to approve or deny the request.

(b) If a provider requests prior authorization, the provider and enrollee must be notified if the authorized facility or provider is out of network.

(2) Issuers that require prior authorization for any covered service must accept and process a prior authorization request from participating providers at any time, including outside normal business hours.

(3) In addition to other methods to process prior authorization requests, issuers that require prior authorization for procedures must have an electronic, interactive process that is browser-based to facilitate a prior authorization request.

(4) Issuers must have a process that allows specialists the ability to request a prior authorization for a clinically recognized course of treatment based upon a review of medical records in advance of seeing the enrollee.

(5) Each issuer must have written procedures to assure that prior authorization determinations are made 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 prior authorization 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.

(6) The time frames for issuer review determination and notification are as follows:

(a) For standard prior authorization requests:

(i) If sufficient information has been provided to the issuer to make a decision, the issuer has 72 hours once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the issuer to make a decision, the issuer has 48 hours to request additional information from the provider.

(A) The issuer must give a provider 72 hours to give the necessary information to the issuer.

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

(b) For expedited prior authorization requests:

(i) If sufficient information has been provided to the issuer to make a decision, the issuer has 24 hours once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the issuer to make a decision, the issuer has 24 hours to request additional information from the provider.

(A) The issuer must give a provider 24 hours to give the necessary information to the issuer.

(B) The issuer must then make a decision and give notification within 24 hours of the receipt of the information or the deadline for receiving information, whichever is sooner.

(7) Prior authorization determinations shall expire no sooner than 45 days from date of approval.

(8) Each issuer when conducting prior authorization must:

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

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

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

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

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

(f) Base review determinations solely on the medical information obtained by the carrier at the time of the review determination.

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

(10) An issuer must ensure that subcontractors of its contracted providers and facilities comply with the requirements of this section. An issuer's obligation to comply with these requirements is non-delegable; the issuer is not exempt from these requirements because it relied upon third-party vendor or subcontracting arrangement.

(11) In limited circumstances when enrollees have to change plans due to an issuer's market withdrawal, subsequent issuers must recognize the prior authorization of the previous issuer and ensure that the enrollee receives the services that were previously authorized as an in-network covered service.

(12) Each carrier must maintain a documented prior authorization program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. A carrier need not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

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

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

(14) Any changes to prior authorization procedures constitutes a change to a provider agreement and is subject to the requirements of Chapter 284-170 WAC.

Effective date: January 1, 2017.

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