The Association of Washington Healthcare Plans

January 3, 2017 submitted electronically

Jim Freeburg
Division of Policy, Legislative and Legal Affairs
Office of the Insurance Commissioner
P.O. Box 40258
Olympia WA 98504

Re: R-2016 - 19 Prior Authorization Transparency rules
CR 102 comments

Dear Jim:

Please accept these comments on behalf of the Association of Washington Healthcare Plans, (AWHP). AWHP represents health plan issuers participating in the Medicaid, commercial and public sector markets in Washington state, covering over 5 million Washingtonians. We look forward to continuing to work with the Office of the Insurance Commissioner (OIC) on the Prior Authorization Transparency rules (R-2016-19).

We do have grave concerns that the currently proposed rule text is materially flawed and should not be adopted as proposed. The asserted problems the OIC wishes to address aren't solved but exacerbated by the rule. The rule also imposes unreasonable levels of cost and complexity without achieving a corresponding or greater benefit, and tries to solve one-off issues at a macro level. While these comments are lengthy, the level of detail hopefully will assist the Commissioner in developing rules that accomplish his stated goals.

Withdraw and Revise the CR102 We respectfully recommend that the OIC revise the CR 102, limiting the scope to align with the originally stated scope as stated in the CR101, and address online systems and "other requirements" in a separate rulemaking, consistent with the requirements of chapter 34.05 RCW, and specifically RCW 34.05.328.

This rule set represents a significant legislative rule, as defined by RCW 34.05.328 (5) (c) (iii):

"A "significant legislative rule" is a rule other than a procedural or interpretive rule that (A) adopts substantive provisions of law pursuant to delegated legislative authority, the violation of which subjects a violator of such rule to a penalty or sanction; (B) establishes, alters, or revokes any qualification or standard for the issuance, suspension, or revocation of a license or permit; or (C) adopts a new, or makes significant amendments to, a policy or regulatory program."

As such, we look to the narrative portions of the CR 101 and CR102 to explain the reasons and goals for the rule making, to explain the pressing reasons for a significant amendment to the Commissioner's policies around prior authorization. The narrative doesn't assist in determining what the OIC wants to accomplish with these rules, and the general statements regarding standardization and streamlining aren't instructive.

Additionally, the OIC dramatically broadened the intended scope of the rulemaking from the CR101 to the CR102 by imposing on line systems requirements as well as "other requirements" that weren't contemplated by the CR101.

In the CR 101:

> In an effort to facilitate access to covered services, the Commissioner wishes to standardize the process of prior authorization when such a program is in effect. These rules are intended to streamline the prior authorization process and to ensure it is more transparent for consumers and providers.

In the CR 102:

In an effort to facilitate access to covered services, the Commissioner wishes to standardize the process of prior authorization when such a program is in effect. These rules are intended to streamline the prior authorization process and to ensure it is more transparent for consumers and providers. The rules require issuers to have online systems to process prior authorizations in a reasonable timeframe. The rules also provide other requirements for issuers to follow related to prior authorization.

By broadening the scope of the rulemaking at the CR102 stage, the requirements of the Administrative Procedures Act (APA) related to justification for significant legislative rulemaking, and the threshold requirements for the notice and comment due process under the APA aren't met.

Scope of the Rule – Legislative Authorizing Environment The sections being implemented, according to the CR 102, are RCW 48.43.520 (utilization review program must be documented), RCW 48.43.525 (issuers can't retroactively deny prior authorized services) and RCW 48.165.0301 (directive to OIC to adopt the OneHealthPort standards for prior authorization as reported to the legislature in 2015). We note concerns in that:
(1) the legislature's directive in RCW 48.165.0301 was to only adopt the OneHealthPort workgroup prior authorization recommendations without change. The Commissioner already adopted those recommendations (see, R-2016-02);
(2) the rules contain a directive to build expensive information systems. This is not contemplated by the statutory direction granting rulemaking authority in either RCW 48.43.520 or 48.43.525, as the statutes being implemented address documenting standards, and the right to rely on prior authorization when it is granted. Not even the 2009 legislative effort described in RCW 48.165.050 requires the scope of build

contemplated by the rule set – the legislature envisioned developing a standard for providing information about the preauthorization, benefit advisory and preadmission requirements of an issuer – not an entire patient-specific preservice claims adjudication system;
(3) RCW 48.43.520 specifically requires issuers to make criteria available upon request. The scope and breadth of this rule goes far beyond that specific, clear requirement by requiring provision of information tied to the member's specific plan, specific facilities and providers and cost share information, none of which are part of prior authorization criteria or programs.

Major Change in a Time of Uncertainty AWHP's recommendation to separate the rulemaking into phases also makes sense due to the pending changes to health care coverage anticipated from the new federal administration and Congress. Based on the Commissioner's recent letter to Congressional leadership and press releases about the proposals to "roll-back" the Affordable Care Act, we know the Commissioner is aware and concerned about the material effect these anticipated changes will have on health issuers and providers. Implementing changes of the broad scope and cost represented by these rules is a real burden when we also face implementation of future federal changes. This alone is a compelling reason for the Commissioner to limit the scope of this rulemaking by eliminating the provisions requiring major process and infrastructure change.

We welcome the Commissioner's continued mentoring of substantive stakeholder engagement on those topics, and the actual need for changes rather than adding greater uncertainty and change to the health coverage marketplace. It is critical that issuers be wise stewards of premium dollars and focus their time and financial resources on the issues that must be changed in order to comply with any changes to state and federal law. Separating the rulemaking into phases makes good sense in a time of uncertainty.

1. Technical Recommendations:

Rule Organization The new section, WAC 284-43-2050, would benefit from being broken into several separate sections, as disparate topics are addressed within the rule as currently proposed. We attach a grid to explain this in more detail. An example includes the reference to information systems-based technology to support prior authorization, and standards for review of prior authorization. Because they are separate topics, for ease of reference and understanding we recommend creating several rule sections rather than an omnibus rule covering every aspect of the prior authorization. This simplifies implementation for issuers as well, as rule sections that don't pertain to the same area of operations aren't intermingled, and confusion is lessened.

Title Correction Even though the title is not part of the rule, it still guides readers in determining where a topic is addressed. The amendments to WAC 284-43-2000 result in the rule title no longer conveying the actual subject matter of the rule. We recommend revising the rule title to indicate that it addresses only concurrent

review and post-determination review, since the remainder of the aspects of utilization management are now defined as prior authorization and addressed in separate rule sections.

Reference to Carrier We recommend as well that the references to "carrier" in the rule be changed to "issuer", as the more common, modern usage. We note that "issuer" is defined in RCW 48.01.053 and encompasses the entities affected by the rule.

Please Use Neutral Language The provisions in WAC 284-43-2050 (5) (a) were identified during every stakeholder meeting as including inflammatory language not suitable to an administrative regulation. We asked that the language referencing the clear and simple explanation of a decision be revised to remove terms such as "resort to". As currently worded, the requirement contains a presumption by the OIC of mal-intent by issuers.

We recommend that the sentence in question be revised from "The response must give the true and actual reason in clear and simple language so that the enrollee and the provider or facility will not need to resort to additional research to understand the real reason for the action."

To:

"If the request is denied, the response must be stated in clear and simple language, and explain the issuer's specific rationale for the decision."

Unnecessarily Redundant Regulation We also question the inclusion of WAC 284-43-2050 (5)(a) in this rule, given that the Commissioner already has extensive regulation in place for the content and format of adverse benefit determinations in chapter 284-43 WAC, subchapters E, F, G. Inserting parallel standards into another part of chapter 284-43 WAC creates the risk of conflicting language, and is redundant. We recommend striking this from proposed WAC 284-43-2050, given that the standards are more clearly spelled out in other parts of the chapter.

Implementation Dates Create Absence of Regulation During 2017 The implementation dates appear to result in a period where WAC 284-43-2000, WAC 284-43-2060 and the definitional changes become effective 31 days after the rule is adopted, but the new section with the turnaround times and standards related to the various prior authorization process elements become effect January 1, 2018. As a result, there won't be utilization management standards in place for prior authorization from the date the rules become effective until January 1, 2018. Given our comments below on the implementation timeframe, we recommend a longer implementation period overall, applying it to the entire proposed set of rule changes, or clarifying when the amendments to WAC 284-43-2000 take effect to avoid this result.

2. Substantive Recommendations:

Extenuating Circumstances Section We appreciate your efforts to revise the extenuating circumstances section, WAC 284-43-2060, based on stakeholder feedback. However, the section continues to permit providers to claim extenuating circumstances to unreasonably avoid complying with prior authorization requirements. There may be reasons that a provider is unable to obtain prior authorization, which are entirely legitimate. Most issuers have post-determination authorization processes that already address circumstances where typical prior authorization processes can't be followed. Issuers determine the need for prior authorization based on member and provider utilization and cost, which is unique to each issuer. Issuers limit the use of prior authorization, as prior authorization also requires issuers to use additional resources and incur costs. This section undermines established processes and the purposes of prior authorization: to prevent questionable billing by providers, reduce inappropriate utilization of key services, and to address issues related to documentation and assessment of medical necessity up front.

Please review the suggested revisions to the section in the attached grid.

Inclusion of Prior Authorization Programs in the Provider Contract is a Damaging Public Policy WAC 284-43-2050 (19) was not amended, despite multiple stakeholder comments that requiring entire prior authorization program language, standards and requirements be included in provider contract agreements is unreasonable, since contracts would need to be reopened every single time anything in a prior authorization program is adjusted, streamlined, corrected or updated. Contract amendments often result in protracted negotiations, and disrupt issuer ability to maintain networks. There is not a common "contracting cycle" that can by synced up to changes in prior authorization standards, particularly clinical practice changes that require amendment to or establishment of prior authorization for a service. The OIC's rule text is unclear as to whether the Commissioner expects every procedure, policy, clinical standard and form to be included in the contract, or if the contract is expected to explain that prior authorization is required for some services, and how the program operates in general. Since provider contracts today reference prior authorization as a process the provider agrees to participate in, the ambiguity of the proposed text is troubling. We ask the Commissioner to eliminate this provision in its entirety.

As discussed during our stakeholder meetings with the Commissioner's staff, if the issue is that providers don't know about a prior authorization requirement because the notices go to someone else in their practice, including the nuts and bolts of prior authorization in the provider contract won't solve that problem – provider groups do not routinely disseminate the contract to the providers themselves. While the operational process of claims adjudication, which includes assessment of whether the procedure was medically necessary, results in reimbursement (or non-reimbursement), it is a stretch to require this one aspect of claims management to be included in its entirety in the provider contract on the basis that the Commissioner receives compensation agreements as part of the provider contract. We note that in the Washington State Hospital Association's June 2016 comment letter, submitted as part of the stakeholder process, WSHA references taking an approach to changes to prior authorization *similar to* that taken with amendments to provider contracts – providing

notice and lead time of changes before they are implemented. They do not advocate including prior authorization requirements in the actual contract.

AWHP's members agree that more can be done to support notifying providers about what is expected. Claims are rarely denied solely for not obtaining prior authorization. We suggest deferring this issue to subsequent rulemaking after a meaningful stakeholder process led by the OIC. Provider education, documented advance notice with sufficient time to provide the opportunity for discussion, and ensuring that providers understand that prior authorization for one line of business, such as Medicaid, will be different than prior authorization for a commercial policy are components of this requiring additional exploration before taking this approach. The Commissioner otherwise is asking issuers to try to solve what appears to be communication and process problems internal to provider groups; provider groups have responsibility to ensure that information is appropriately shared, which is ignored by the current version of the rule.

Length of Time Prior Authorization in Effect: The 45-day binding period proposed at WAC 284-43-2050(14) will have a significant impact on the prior authorization process. Enrollees may switch plans, switch issuers, or even have a change in clinical status/medical necessity that no longer warrants authorization for a particular service. This also creates a conflict with the 30 day (or longer) authorization requirements in (17), as based on this, prior authorization would be for 45 days, and a shorter period is not contemplated.

We ask the Commissioner to consider limiting or striking this section. At a minimum, we request clarification that the preceding issuer's prior authorization decision is only in effect until the new issuer's prior authorization process can be completed.

Cost of Information Systems Build The information systems build required by the rule is costly to both issuers and providers. The OIC noted a $3 million estimated cost per issuer, although we're unclear as to the basis for that determination and know it is too low an estimate, given ongoing staffing and the complexity of the deliverables required by the proposed rule. In addition, the OIC rule requires that the systems go-live by January 1, 2018. A build of this type cannot occur in less than 18 months – 24 months for issuers who are AWHP members and that must be followed by training for providers and their staff. Further, if the OIC persists in requiring the entire program to be part of the provider contract, it will take a minimum of 18-24 months to effect that change. The implementation dates and cost estimates seem arbitrary, as they do not reflect the specific feedback received from both issuers and providers.

The rules are also still unclear as to what it is that we're expected to build. There is a difference between posting information and actually providing a portal for document submission, acknowledgment and access. To provide adjudication information as part of that website facing system creates even more complexity.

Additionally, the build is one-sided, and may not even be used. We know from past pilots around the country conducted by some of our members that providers do not

readily accept this type of submission process. They prefer phones and fax. It is unreasonable to ask issuers to build and maintain costly systems before there is provider acceptance and willingness to forego alternate concurrent processes.

Specific Language Comments Additional specific comments with language revision suggestions are contained in a section by section grid attached to this letter. Thank you for your anticipated thoughtful consideration of our comments.

Sincerely,

Molli Robertson
Association of Washington Healthcare Plans

Encl.: Appendix with section by section comments

AWHP is an alliance of licensed Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), & Disability Insurers. Its diverse membership is comprised of local, regional, & national healthcare plans of varying size, serving the needs of consumers, employers, & public purchasers. Together, they provide health care coverage to over 5 million residents of Washington State. AWHP members include Aetna, Amerigroup, Cambia Health Solutions, CIGNA, Community Health Plan of WA, Coordinated Care, Group Health Cooperative, Health Net, Kaiser Permanente, Molina Healthcare, Premera Blue Cross, Providence Health Plan, & UnitedHealthcare.

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
WAC 284-43-0160 (amended)				
(10) "Expedited prior authorization request" means any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request.	Adds a new definition to the general definition section of chapter 284-43 WAC, defining an expedited review request. Appears to replace category for UR of "urgent" requests for prior authorization/concurrent review (see changes to WAC 284-43-2000) Note: based on the timeframes, can take up to 5 days to approve such a request if initial request incomplete	What is the basis for including a new category and deleting the "urgent" category? Since it is now in the general definitions section, may conflict with references in other parts of chapter 284-43 WAC.		
(29) "Predetermination request" means a voluntary request from an enrollee or provider or facility for a carrier or its designated or contracted representative to determine if a service is a benefit, in relation to the applicable plan.	New category of decision making by issuer– differs from prior authorization as it simply determines whether a service is a benefit under a plan.	The phrase "determine if a service is a benefit" is used throughout the rules. What does the phrase mean? Is the OIC applying this to mean a decision that the service is covered? Or just that the		

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		service is a referenced benefit in the member's plan, subject to medical necessity review and other coverage determinations. Differs from the definitions related to medical management in chapter RCW 48.165. Unclear how to align.		
(30) "Preservice requirement" means any requirement that a carrier places on a provider or facility that may limit their ability to deliver a service that requires prior authorization. Examples include limits on the type of provider or facility delivering the service, a service that must be provided before a specific service will be authorized, site of care/place of service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.	New definition added to general definitions section. The defined term is used in the new rule sections as a category of information that must be explained as part of prior authorization programs. The rules do not place requirements on preservice requirements.	See comment, above, re other definitions.		
(34) "Prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow to determine if a service is a benefit and meets the clinical requirements for medical necessity, appropriateness, level of care, and effectiveness in relation to the applicable plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any term used by a carrier or its designated or contracted representative to describe this	Definition of prior authorization - ties to determination of whether service is a benefit AND meets clinical criteria, and limited to situations before service is delivered.	Prior authorization can also tie to clinical requirements for place of service, and that should be inserted in this definition. Better than earlier iterations, as it ensures that a general question about coverage parameters, etc. isn't treated as prior authorization decisions. Please retain that distinction. However, it is still confusing:	(34) "Prior authorization" means a ~~mandatory~~ process that ~~a carrier~~an issuer or its designated or contracted representative requires a provider or facility to follow to determine if a service ~~is a benefit and~~ meets the clinical requirements for medical necessity, clinical appropriateness, level of care, place of service, ~~and~~ or effectiveness, in relation to the ~~applicable~~ enrollee's plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any	

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process is prior authorization. For example, prior authorization has also been referred to as "preauthorization," "prospective review," "preauthorization," or "precertification."		due to use of the phrase '*determine if a service is a benefit'*. Does "benefit" imply medically necessary, or merely that the requested service is covered? (i.e. – some services, such as those deemed Experimental/Investigational, are not covered regardless of the existence of a PA Program; other services, such as diagnostic radiology, are generally covered, but may not be deemed medically necessary based on evidence based clinical indications).	term used by a carrier or its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "preauthorization," "prospective review," "preauthorization," or "precertification."	
(37) "Standard prior authorization request" means any request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service.	Means a non-expedited request, and carries a longer timeline for decision making.	Note that the distinction between the two prior authorization sections appears to be the member's condition. Suggest adding language that clarifies the immediacy of the need for the service is not at issue for "standard" PA.	(37) "Standard prior authorization request" means ~~any~~ a request for prior authorization of a service by a provider or facility for approval of a service ~~where the request is made in advance of the enrollee obtaining a service~~where the member's condition does not warrant an expedited decision.	
WAC 284-43-2000 (amended)				
DELETED (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	Deletes category of "immediate review request". Expedited review request definition uses some of this language to define that new category.	Changes the scope of the UR rule from a general one encompassing concurrent review, prior auth, preservice and post service determinations to only addressing concurrent	New title for rule section: **Concurrent and Post-service Review and Authorization**	

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
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.	The deleted “non-urgent preservice review request” appears to be covered by either the “preservice requirement” definition or the “standard prior authorization request” definition.	and post service review of coverage. Does this meet NCQA or other standards? Change the title of the rule to reflect the changes. Because the OIC deleted “immediate review request” as a defined term, does the defined term (10) “expedited prior authorization request” now apply to this section?		
(((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	Appears to be replaced by the “Expedited Prior authorization request” as the same defining language is used	What is the intended difference between expedited and urgent review requests?		

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
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 and facilities. An issuer need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.	Makes the UR program and clinical review criteria applicable to facilities as well as providers.			
(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;	Deletes requirements for prospective review from this section of chapter 284-43, limiting requirement to concurrent review situations where these decisions are being made (typically tied to facility based services requiring admission)			
(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;	Id.			
(g) For retrospective review, base review determinations solely on the medical	Removes reference to "attending" and makes			

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
information available to the ((attending physician or order)) provider or facility at the time the health service was provided;	retrospective review requirements applicable to non-facility based services as well			
(6)(a) Review time frames must be appropriate to the severity of the ((patient)) enrollee condition and the urgency of the need for treatment, as documented in the review request.	Technical change – inserting term "enrollee" for consistency	Suggest changing term "enrollee" to "enrollee's"	6)(a) Review time frames must be appropriate to the severity of the ((patient)) enrollee's condition and the urgency of the need for treatment, as documented in the review request.	
(b) If the review request from the provider or facility is not accompanied by all necessary information, the issuer must tell the provider or facility 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: **DELETED SECTIONS START HERE** (((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	Adds language to make section applicable to facilities as well as providers, broadening scope of the rule section. Deletes language explaining DOL standards that must be complied with, resulting in 100% compliance with DOL standards as the baseline. Removes timelines for response to: • immediate request situations (which were 1 day vs. 2 day for new category of expedited requests).	Section 6 now applies only to concurrent review and to post service review. The timeline for post service review is 30 days; no timelines are expressed for concurrent review, but since concurrent review meets the definition of prior authorization, may we assume those time lines apply? However, a rule should not require an "assumption in order to implement it. Suggest that a specific definition of concurrent review be added to the rule for clarity, or that clarifying language for when concurrent review occurs, whether the same prior auth categories are applicable and what the timelines are.		

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
least twenty-four hours prior to the expiration of previously approved period of time or number of treatments; (iii) For urgent care review requests: (A) The issuer must approve the request within forty-eight hours if the information provided is sufficient to approve the claim; (B) The issuer must deny the request within forty-eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or (C) Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination: (I) The issuer must give the provider forty-eight hours to submit the requested information; (II) The issuer must then approve or deny the request within forty-eight hours of the receipt of the requested additional information. (iv) For nonurgent preservice review requests, including nonurgent concurrent review requests: (A) The issuer must approve the request within five calendar days if the information is sufficient to approve the claim; (B) The issuer must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or	• Concurrent review requests that are also urgent (24 hours vs. 0 time frame now) • Urgent care review: (48 hour vs. 2 days now for expedited) and changes time frame for additional information • Nonurgent preservice review (now standard prior auth) and concurrent review situations (rolled into the prior auth?): timeline removed here is replaced with same standard in new section.			

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
(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.				
For post service review requests, within thirty calendar days.	This section remains in the rule .			
	Broadens scope of rule to include facilities, and removes reference to attending or ordering physician, replacing it with just provider. Changes “covered person” to enrollee Removes requirement to comply with DOL standards.			
NEW SECTION	**WAC 284-43-2050 Prior Authorization Processes**			
(1) This section applies to health benefit plans as defined in RCW 48.43.005,	Scope and applicability	• States that the rule applies to health plans; however, the		

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018.	section. Effective date of 1/1/18 for these changes.	remaining sections all apply to carriers, not the plans. By applying to "plans," implies this is a mandate related to plan design. If applies to carriers, applies to carrier operations. Suggest revising depending on the OIC's intent. • If this section is effective 1/1/18, and other sections are effective when the rule is adopted (or within 31 days), a vacuum is created in terms of TATs and definitions to use between adoption in 2017 and the effective date of these sections. SUGGESTION: entire rule amendment occurs in 2018, not just the new sections.		
(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use medically acceptable clinical review criteria. A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria. The prior authorization program must include a method for reviewing and updating clinical	Establishes multiple requirements that address both the requirement to have a prior authorization program and how the program must make decisions.	• Suggest breaking this into separate subsections or rule sections for readability, ease of reference and comprehension. See potential revision. • The language used in WAC 284-43-2000 is clearer – suggest referencing that for revisions.	(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use ~~medically acceptable~~ evidence based clinical review criteria. ~~A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria.~~ The prior authorization program must	

Commented [W1]: Place in a separate section that deals with standards for decision making.

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
review criteria. A carrier or its designated or contracted representative must not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.		• What are "medically acceptable" clinical review criteria? Why are there now 2 different standards: concurrent and post review must include medical /clinical standards which are evidence based, while these must only be "medically acceptable? RECOMMEND: use the phrase "clinical standards that are evidence based."	include a method for reviewing and updating clinical review criteria. ~~A carrier or its designated or contracted representative must not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.~~	
(3) The prior authorization program must meet accreditation standards by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), Joint Commission, URAC, and AAAHC in addition to the requirements of this chapter. The prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.	Requires prior auth programs to meet a national accreditation organizations standards in addition to the OIC standards. Requires trained staff	• Two acronyms are not spelled out (URAC and AAAHC) – should use same convention used for NCQA • Suggest making the staffing requirement part of the standards for subsection (2) above, rather than the accreditation subsection. • Appears to mandate NCQA or other national accreditation – this is costly and unnecessary for small plans, or for dental only or vision plans. Would also deter plans from entering WA market. Please revise to confirm that if standards	Move last sentence to subsection (2) of this new section)	

Commented [W2]: Place in a separate section that deals with standards for decision making

CR102 Section	Effect	Comments	Potential Revisions	Cost Implications
		pertain, they should be met, but that accreditation is not necessary from each organization.		
(4) A carrier or its designated or contracted representative must have a current and accurate online prior authorization system. The online system must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. The online system must include sufficient information for a provider or facility to determine for an enrollee's plan: (a) If a service is a benefit; (b) If a prior authorization request is necessary; (c) If any preservice requirements apply; and (d) If a prior authorization request is necessary, the following information: (i) The clinical review criteria used to evaluate the request; and (ii) Any required documentation.	Requires an "online" system tied to prior authorization that provides information to providers and facilities for prior authorization that is specific to each plan design. NOTE not required to be available to enrollees or group administrators.	• This requirement appears to require an "informational" site that permits providers/facilities to identify plan design, and associated clinical review standards, and provides instructions on how to document to those standards. Because this is a separate requirement from the browser requirement in subsection (5), can this be a site that is separate from the browser based submission requirement (see section (5)). • Unclear how the information system can also provide member specific analysis as required by this section		Requires investment in infrastructure – IT systems Concerned that the OIC believes that a $3M investment is inconsequential in the rule cover sheet (PER PLAN). What is this based on? Is it annual or one-time? Does it include staffing for the member specific analysis?
(5) In addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for services must	Separate requirement for a prior authorization browser based electronic process to receive and complete a	• Insufficient time to build this system and train providers by 1/1/18 – • Delay may be prudent given		Difficult to tell without greater clarity of what is required. The build

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have an electronic process that is browser-based for a participating provider or facility to upload documentation and complete a prior authorization request.	prior authorization request.	the uncertainty re cost and implementation required if the anticipated ACA reforms occur, which will also affect systems and resources for issuers. • Low compliance when this has been attempted by issuers • Implementation and compliance expectations still unclear: while the requirement that it be iterative is removed, what is the definition of "completing" a request? • Would it be clearer/easier to remove the reference to electronic process that is browser-based, and change it to "automated submission process" and require a secure location to provide notice to providers/facilities of the status of a request? • Cost to providers, especially smaller ones, unacceptable if they can't support the electronic submission requirement on their end		of systems that adjudicate at the member level are more costly than simply providing information portals. Depending on the actual build being required, costs will be significant to build and maintain. Cost to providers must be included – SBEIS required Some plans are already working on this, in conjunction with the RCW 48.43.007; also can do an issuer survey to determine what systems we have, what we're working on related to prior authorization best practices etc.

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				perhaps via the administrative simplification workgroup.
5 (a) When a provider or facility makes a request for the prior authorization, the response from the carrier or its designated or contracted representative must be clear and explain if it is approved or denied and the justification and basis for the decision including the clinical review criteria for the denial. The response must give the true and actual reason in clear and simple language so that the enrollee and the provider or facility will not need to resort to additional research to understand the real reason for the action. Written notice of the decision must be communicated to the provider or facility, and the enrollee. A decision may be provided orally, but subsequent written notice must also be provided. The denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.	Standards for content of response from issuer to the provider or facility. Denials must designate the department and credentials of the decision maker. Letters to provider/facility re decision must include the enrollee's appeal rights.	• Suggest this be moved to a separate full section that sets out the requirements for the content of the process (see earlier comment). It's not really related to the "browser" requirement. • Please remove the "true and actual" and "have to resort to" language. It is antagonistic, and infers issuers are trying to confuse the consumers and providers. The requirement should be stated in neutral language. • Note that the adverse benefit determination regulations address the standards for the content of prior authorization denials. Recommend deleting this language since those regulations already set the	~~The response must give the true and actual reason in clear and simple language so that the enrollee and the provider or facility will not need to resort to additional research to understand the real reason for the action~~ REPLACE with: If the request is denied, the response must be in clear and simple language that explains the issuer's specific rationale for the decision.	

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		standard. Shouldn't have different standards for the same document in two places in the regs. • Please remove reference to the enrollee here – it is confusing since the rules discuss prior authorization requirements between the issuer and provider. The Adverse Benefit Determination rules explain issuer obligations to the member.		
5 (b) A prior authorization approval notification for all services except prescription drugs must include sufficient information for the requesting provider or facility, and the enrollee, to know whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out-of-network provider or facility and if so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.	Requires prior authorization be tied to a specific provider or facility. Requires issuer to notify of OON access options Requires issuer to disclose cost to member if received OON	• Please see prior AWHP comments on this in August, October 2016. • Prior authorization is not typically done based on a specific provider or facility. The decision is tied to the appropriateness of the service, unless the PA is tied to site of service. This implies that there would need to be a prior authorization for provider A, then provider B etc. etc. • The Out of Network (OON) option is complex, and drives plan design; as a	5 (b) ~~A prior authorization approval notification for all services except prescription drugs must include sufficient information for the requesting provider or facility, and the enrollee, to know whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out-of-network provider or facility and if so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.~~ An issuer's prior authorization process must include instructions about how to ask the issuer to limit an authorization to a specific provider or facility.	

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		result it would not be in scope for prior auth staff. Similarly, the OON cost share can't be known until after the service is received and is related to plan design and member's utilization to date. Member certificates of coverage direct them to call the customer service number on their ID card to get answers to OON and cost share questions. • Again, RECOMMEND the OIC move to this to a separate section that is limited to standards for the process for prior auth (vs. this section which requires a specific way of interacting with providers/facilities on prior auth. • What problem is the OIC trying to solve with this language? If a member sees an out of network provider and needs prior authorization for the procedure, the process is spelled out for them in their coverage documents.		

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(6) The carrier or its designated or contracted representative must have a method that allows an out-of-network provider or facility to request a prior authorization if prior authorization is required for an out-of-network provider or facility.	Requires OON prior authorization if available under plan design	• Suggest removing this subsection in its entirety because this is actually addressed through the OIC's Network access/adequacy AADR process. 1. OON access is determined by a separate part of most companies, as it is tied to the specific plan and the access available via the network, NOT to prior authorization criteria. Typically a member/provider/facility would determine the need for the service, get the authorization and then find an in network provider. If one isn't available, they'd work with the health plan customer service team to identify an OON provider to go to. If they have a plan with variable coverage based on IN / OON status, the prior authorization would already be in place. 2. Permitting OON providers to seek prior authorization unnecessarily undermines the issuer's ability to encourage members to use		

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		IN providers. Suggest removing this section.		
(7) The carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to request a predetermination when provided for by the plan.	Requires issuers to have a predetermination process when provided for by the plan	• The wording of this is confusing. It reads that a method is required for predetermination when a plan has a predetermination process. What is the difference between a method and a process? • Think that the draft is missing the word "request" – see suggested revision	(7) If a plan design permits predetermination requests for a specific service or benefit, the~~The~~ carrier or its designated or contracted representative must ~~have a~~explain the method as part of the prior authorization process that allows an enrollee, provider or facility to ~~request a predetermination~~make such a request. ~~when provided for by the plan.~~	
(8) A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted. (a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted by a provider or facility during the processing of a prior authorization request. (b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information	Prior authorization process must include a way to track what's been submitted by providers and facilities. Submitted information must be kept until the claim is paid or the appeal process is exhausted. If asked, an issuer must acknowledge receipt of documents. If information is received by phone, the issuer must acknowledge it in writing.	• This could be "plain-talked" - see suggested revision. • Not sure how to document telephonically received information – or a timeframe for sending it to the provider/facility. This section is unclear and will result in inconsistent implementation and not meet the criteria for this rule of standardizing processes. • If the documentation of phoned info remains, can the documentation be in email format? • How is this section to be harmonized with the requirements in WAC 284-	8) A carrier or its designated or contracted representative must be able to confirm upon request by the provider or facility that a document was received from a provider or facility as part of a prior authorization request. Carriers or their representatives may not destroy, archive or delete documentation received in support of a prior authorization request until the claim is paid or the appeal process is exhausted.A carrier or their representative must include a method to track and identify information received by telephone from a provider or facility, and document that for the decision maker. ~~A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while~~	

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communicated by the provider or facility.		43-3030 to retain all documents related to an adverse benefit determination for six years?	~~requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted.~~ ~~(a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted by a provider or facility during the processing of a prior authorization request.~~ ~~(b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information communicated by the provider or facility~~.	
(9) A carrier or its designated or contracted representative that requires prior authorization for any service must allow a provider or facility to submit a request for a prior authorization at all times, including outside normal business hours.	Issuers must be able to accept a request at any time.	• Better than stakeholder draft. Thank you for amending.		
(10) A carrier or its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations for a participating provider or facility are made within the appropriate time frames. (a) Time frames must be appropriate to the severity of the enrollee condition and the	Requires P&P related to timeframes for a prior auth decision. Sets standards for the P&P based on enrollee need. Requires clear	• Suggest use the same language in WAC 284-43-2000 on this aspect. • Move into a separate section that sets out what has to be included in the "documented prior authorization program."		

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urgency of the need for treatment, as documented in the prior authorization request. (b) If the request from the participating provider or facility is not accompanied by all necessary information, the carrier or its designated or contracted representative must inform the provider or facility what additional information is needed and the deadline for its submission as set forth in this section.	communication of additional information needed.			
(11) The time frames for carrier prior authorization determination and notification to a participating provider or facility are as follows: (a) For standard prior authorization requests: (i) If sufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has five calendar days once the information has been received to make a determination and provide notification. (ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has five calendar days to request additional information from the provider or facility. (A) The carrier or its designated or contracted representative must give a	Sets out time frames for types of requests. Includes ability of issuer to request additional information, and timeframe for determining need, request and TAT after receipt.	Suggest splitting into 3 separate sections that spell out, for each type of request, the timeframes applicable.		

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provider or facility five calendar days to give the necessary information to the carrier or its designated or contracted representative. (B) The carrier or its designated or contracted representative must then make a decision and give notification within four calendar days 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 a carrier or its designated or contracted representative to make a decision, the carrier has two calendar days once the information has been received to make a determination and provide notification. (ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has one calendar day to request additional information from the provider or facility. (A) The carrier or its designated or contracted representative must give a provider or facility two calendar days to give the necessary information to the carrier or its designated or contracted representative. (B) The carrier or its designated or contracted representative must then make a decision and give notification within two calendar days of the receipt of the				

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information or the deadline for receiving information, whichever is sooner. (iii) If the time frames for the approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.				
12) A carrier or its designated or contracted representative when conducting prior authorization must: (a) Accept any evidence-based information from a provider or facility that will assist in the authorization process; (b) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit such records; (c) If medical records are requested, require only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the service to be delivered, to include admission or extension of stay, frequency or duration of service; (d) Base review determinations on the medical information in the enrollee's records and obtained by the carrier up to the time of the review determination; and (e) Use the medical necessity definition	Sets standards for what must be used in decision making for prior authorization tied to medical necessity/clinical criteria. Limits use of medical records to necessity, and requires issuers to limit requests for information to that necessary to make the decision	• (d) contradicts (a) of this section. Can this be revised to provide alignment for implementation purposes? • Note that there are some procedures for which medical records must be reviewed in order to make a determination.		

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stated in the enrollee's plan.				
(13) A prior authorization denial is an adverse benefit determination and is subject to the appeal process.	As stated.	Not necessary, since this is stated in the Appeals regulations. But no harm having it here.		
(14) Prior authorization determinations shall expire no sooner than forty-five days from date of approval. This requirement does not supersede RCW 48.43.039.	Makes a prior authorization good for 45 days or longer. Exchange grace period requirements continue to apply and must be harmonized.	Is the OIC taking the position that issuers must pay for this service if the person moves to another issuer?		
(15) A carrier must reimburse reasonable costs of medical record duplication for reviews.	Carriers must pay providers for medical records copied for reviews.	Provide some protections for issuers against abuse by providers/facilities but does not provide guidance as to "reasonableness" nor from whose perspective it is determined.	(15) When a carrier requests medical record submission, and an electronic medical record cannot be accessed, the~~A~~ carrier must reimburse reasonable costs ~~of medical record~~ for duplication ~~for~~ of the submitted records.~~reviews.~~ A carrier is not required to reimburse for records submitted by a provider or facility that were not requested by the carrier.	
(16) A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. The carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization				

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program.				
(17) In limited circumstances when an enrollee has to change plans due to a carrier's market withdrawal as defined in RCW 48.43.035 (4)(d) and 48.43.038 (3)(d), the subsequent carrier or its designated or contracted representative must recognize the prior authorization of the previous carrier until the new carrier's prior authorization process has been completed and its authorized treatment plan has been initiated. The subsequent carrier or its designated or contracted representative must ensure that the enrollee receives the initial service that was previously authorized as an in-network service. Enrollees must present proof of the prior authorization. (a) For medical services, a carrier or its designated or contracted representative must recognize a prior authorization for at least thirty days or the expiration date of the original prior authorization, whichever is greater. (b) For pharmacy services, a carrier or its designated or contracted representative must recognize a prior authorization for the initial fill, or until the prior authorization process of the new carrier or its designated or contracted representative has been completed.				
(18) Predetermination notices must clearly		• Suggest placing this in a separate rule section related		

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disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered." Predetermination notices must be delivered within five calendar days of receipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan: (a) If a service is a benefit; (b) If a prior authorization request is necessary; (c) If any preservice requirements apply; and (d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information: (i) The clinical review criteria used to evaluate the request; and (ii) Any required documentation.		to predetermination notices rather than burying it in this section.		
(19) Any carrier changes to a prior authorization procedure constitute a change to a provider or facility contract as the term is used in chapter 284-170 WAC and must be made as an amendment.		• Making prior authorization requirements part of the contracts is unreasonable – which means changes result in contract renegotiation in toto, and delays innovation and streamlining based on filing requirements related to contracts. STRONGLY OPPOSE.		

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		• This appears to require inclusion of the entire prior authorization program description and requirements in each provider contract. Is that the intent?		
(20) Prior authorization for a facility-to-facility transport that requires prior authorization can be performed after the service is delivered. Authorization can only be based on information available to the carrier or its designated or contracted representative at the time of the prior authorization request.		If this pertains to non-emergent ambulance transport, it needs to be clearer, and facility to facility transport can be interpreted to mean bus, taxi, Uber or other means of transport. What problem is this section attempting to solve? Note again that issuers permit post service determination; however, if there is a facility-to-facility non-emergent ambulance transport, that is prior authorized as part of concurrent review and potential discharge planning. There isn't a basis for not obtaining prior authorization (if required). The last sentence doesn't make sense – all prior authorization determinations are made based on the information available. What is the issue that this sentence is trying to address?	(20) If an enrollee requires non-emergent transportation, and prior authorization was not obtained prior to discharge from the facility, issuers may ~~Prior authorization for a facility-to-facility transport that requires prior authorization can be~~permit post-service review of the need for the service. ~~performed after the service is delivered~~. ~~Authorization can only be based on information available to the carrier or its designated or contracted representative at the time of the prior authorization request~~	

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(21) Carriers or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee.		The standard of care usually limits a provider from ordering tests without having seen the patient. This requirement subverts good medical practice. Where prior authorization occurs, if there are standing tests necessary to provide a specialist with information, the referring provider orders them and would include them in the prior authorization request. Please delete this section.		
NEW SECTION WAC 284-43-2060 Extenuating Circumstances				
(1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018.	Scope and effective date statement.	See comments for WAC 284-43-2050 (1). Those apply here as well.		
(2) A carrier or its designated or contracted representative must allow the retrospective review of services when an extenuating circumstance prevents a participating provider or facility from obtaining a required prior authorization before a service is delivered. For purposes of this section, an extenuating circumstance means a situation	Adds an exculpatory option for providers/facilities to avoid denial for failure to seek prior authorization, based on some designated situations	• Better, but still not acceptable section. Post-service review options for issuers address situations that this section tries to envision; this section removes the ability of issuers to control	(2) A carrier or its designated or contracted representative must ~~allow~~ include ~~the~~ retrospective review of services in its prior authorization processes, and establish specific, clear criteria stating when the provider or facility may seek retrospective review, and the documentation required to support it.	

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where a carrier must not deny a provider or facility's claim for lack of prior authorization if the services are otherwise eligible for reimbursement. A carrier's or its designated or contracted representative's extenuating circumstances policy must address, but is not limited to situations where: (a) A provider or facility is unable to expect the need for the outpatient service in question prior to performing the service; (b) The provider or facility is unable to identify from which carrier or its designated or contracted representative to request a prior authorization; (c) The provider or facility does not have enough time to request a prior authorization before or while performing a service; and (d) The enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service.		provider/facility abuse and does not set enforceable standards for an acceptable policy & procedure • What actual problem or complaint is this section trying to address? Note that in 2016, Medicare instituted new prior authorization standards to address home health services, due to OIG reports that home health services had a 51.4% improper payment rate. • As currently drafted, the section requires approval of the service if the request is made based on extenuating circumstances. Issuers must still be able to apply medical management protocols to determine whether the service is medically necessary/clinically appropriate.	(2) When an issuer requires documentation to justify the retrospective review, in addition to the documentation necessary to conduct the retrospective review, the process must include a clear explanation of what is required for submission. (3) ~~when an extenuating circumstance prevents a participating provider or facility from obtaining a required prior authorization before a service is delivered. For purposes of this section, an extenuating circumstance means a situation where a carrier must not deny a provider or facility's claim for lack of prior authorization if the services are otherwise eligible for reimbursement. A carrier's or its designated or contracted representative's extenuating circumstances policy must address, but is not limited to situations where~~: ~~(a) A provider or facility is unable to expect the need for the outpatient service in question prior to performing the service;~~ ~~(b) The provider or facility is unable to identify from which carrier or its designated or contracted representative to request a prior authorization;~~ ~~(c) The provider or facility does not have enough time to request a prior authorization before or while performing a service; and~~	

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			~~(d)~~ Issuer prior authorization processes must include direction regarding obtaining non-emergent ambulance transport services or home health services for a member being ~~The enrollee is~~ discharged from a facility ~~and insufficient~~so that time exists for institutional or home health care services to receive approval prior to delivery of the service or retrospective review may be obtained.	
3) A carrier or its designated or contracted representative may require a participating provider or facility to follow certain procedures in order for services to qualify as an extenuating circumstance, such as requirements for documentation or a time frame for claims submission. Claims related to an extenuating circumstance may still be reviewed for medical necessity.				
4) Requirements of WAC 284-43-2000 apply to a retrospective review that occurs because the review occurs after the service has been delivered				
(5) This section does not apply to prescription drugs services.				