January 4, 2017

Virginia Mason
Finance & Administration
P.O. Box 900, Mail Stop M6-FNADM
Seattle, WA 98111

Virginia Mason
Public Policy
P.O. Box 900, Mail Stop D1-PR
Seattle, WA 98111

Mr. Jim Freeburg
Washington State Office of the Insurance Commissioner
PO Box 40260
Olympia, WA 98504
Email: rulescoordinator@oic.wa.gov

Comments on OIC Proposed Rule re: prior authorization processes and transparency, Insurance Commissioner Matter No. R 2016-19 (WSR 16-13-103)

Dear Mr. Freeburg,

We are writing on behalf of Virginia Mason Health System, which includes Virginia Mason Medical Center and Virginia Mason Memorial, to comment on the proposed rules by the Office of the Insurance Commissioner (OIC) on prior authorization practices in this state (WSR 16-23-156). We are pleased that the OIC is willing to adopt rulemaking regarding prior authorizations and we support the overall direction of the proposed rule given the issue's significant impact on health care delivery and public policy.

Virginia Mason Health System includes a nonprofit regional health system in the Puget Sound area and the Yakima Valley region. In the Puget Sound area, we employ approximately 5,500 people and operate a 336-bed acute-care hospital, employ more than 500 physicians in a multispecialty group practice offering both primary and specialty care and have a network of eight medical centers. In the Yakima region, Virginia Mason Memorial employs approximately 2,800 people and operates a 226-bed acute-care, nonprofit community hospital and provides primary care and specialty care services.

As we have noted in previous comments to the OIC, Virginia Mason and other major health systems in Washington have had ongoing,unfavorable experiences with the prior authorization processes required by commercial health insurers doing business in Washington state. Current prior authorization requirements are extremely wasteful, inefficient and neither transparent nor reasonable. At present, Virginia Mason is subjected to seeking prior authorization for at least 364 unique services, which is similar to what other health systems in Washington also are experiencing. Virginia Mason employs 28 FTEs in the Seattle area alone to assist with this process for our Puget Sound operations. Prior

authorization can result in the undesirable interruption of necessary care delivery. When we are required to seek prior approval by payers, **more than 95 percent of Virginia Mason's initial requests are approved**. **When resubmitting our requests, more than half of those initial rejections are then approved**.

Measures to ensure appropriate use of health care resources are important to ensure both safety and affordability of health care. This goal is shared by purchasers, providers, health plans, regulators and individual patients. Unfortunately, health plans in Washington state and across the country increasingly are relying on prior authorization to manage access to many types of health care services and procedures. This results in an ever-increasing cost burden to the health care delivery system as a whole. In addition, patients, who often do not fully understand why prior authorizations are required, are frustrated by what they see as unnecessary roadblocks to accessing care.

GENERAL COMMENTS

There has been a tremendous increase in the number and variation of prior authorizations requirements required by health plans. While the proposed rules do not directly address all our concerns relating to the proliferation and lack of standardization of prior authorization requirements, we believe the provisions in the proposed rule are desirable and beneficial and that transparency and accountability requirements will help create a framework that helps health plans and providers better align clinical criteria to service delivery. We also have the following additional general comments concerning the proposed rules and the technical comments which are set out at the end of this letter.

Timelines and sufficient information

The OIC's proposed rules require health carriers and their designated or contracted representatives to have written policies to assure that prior authorization determinations are made within appropriate timeframes outlined in the rules. **A 72-hour turn-around time is too long.**

T**he OIC rule should be 24 hours for all requests, 7 days per week**. By implementing the preauthorization process, health plans have placed themselves in the flow of health care delivery. Any waits or delays are financially costly and potentially costly from a clinical perspective. Health plan medical directors should be on call to discuss these requests in a timely fashion, just as providers are on call to deliver care 24/7.

While we support rules timeframes, we note that these rules could be meaningless without a **definition of sufficient information** or a requirement that carriers inform providers what is required in advance. What constitutes "sufficient information" should be clearly defined in a manner that is easily understood by support staff.

Extenuating circumstances

The inclusion of "extenuating circumstances" provisions in the proposed WAC, as well as the provisions in WAC 284-43-2050(11)(b)(iii) are very desirable. We concur with the idea that -- in the final rule -- the OIC should include one or more examples for how such types of situations are covered. We agree that both inpatient and outpatient settings should be included in the example(s). Note that the word "outpatient" is included in subsection (2)(a), and should be removed.

Enforcement
It would be preferable for the rules to include a specific enforcement mechanism. However, if the OIC is not going to include a specific enforcement mechanism, we also believe the OIC should understand and recognize that it is the providers who notice patterns of problems and that providers are the advocates for their patients when those patients' health challenges prevent them from taking the time to file a complaint. If no specific enforcement mechanism is included in the final version of these rules, the OIC should develop a specific template for complaints related to prior authorization.

We thank you for the opportunity to comment on the proposed rules. If you have any questions concerning these comments, please do not hesitate to contact me, or Virginia Mason's Public Policy Director, Ross Baker (ross.baker@virginiamason.org, (206) 399-4481).

Sincerely,

Bill Poppy
Senior Vice President of Provider Contracting and Chief Information Officer
Bill.Poppy@VirginiaMason.org
(206) 223-6606

cc: Russ Myers, Virginia Mason Memorial
Kathleen Paul, Virginia Mason Medical Center
Leif Ergeson, Virginia Mason Memorial
Claudia Sanders, Washington State Hospital Association
Andrew Busz, Washington State Hospital Association

TECHNICAL EDITS

- While numerous changes have been made, for example, to include both facilities as well as providers, there remain some inconsistences in language. While these inconsistencies do not necessarily lead to major problems, the OIC should consider an additional review of the proposed rules that are a part of this rule filing to see if any technical issues need updating is needed. (The comments below include several suggestions in this regard).

Concerning specific edits to the proposed rules, edits are made in red ink and underlined, while comments in the form of rationales or questions are in blue ink.

WAC 284-43-0160 Definitions.

Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health ~~carrier's designee~~ carrier or its designated or contracted utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its ~~designee~~ designated or contracted utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable ((~~health~~)) plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan. **(**PLEASE NOTE THAT some of the rule edits are inconsistent. While the term "plan" and "health plan" mean the same thing, it would seem more appropriate to choose one as the dominate term.**)**

(5) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a patient presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

(7) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result

in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(8) "Emergency services" has the meaning set forth in RCW 48.43.005.

(9) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(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. **(The word "service" is not defined. But, since it is used so frequently in the newer rule language, we are suggesting an edit below to the definition of "health care service" or you can use the words "health care service" or "health service" which are defined.)**

(11) "Facility" means an institution providing health care services((~~,~~)) including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

((~~(11)~~)) (12) "Formulary" means a listing of drugs used within a health plan.

((~~(12)~~)) (13) "Grievance" has the meaning set forth in RCW 48.43.005.

((~~(13)~~)) (14) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

((~~(14)~~)) (15) "Health care service" ~~or~~, "health service" or service means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(15)~~)) (16) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or

48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

((~~(16)~~)) (17) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(17)~~)) (18) "Immediate therapeutic needs" means those needs where passage of time without treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

((~~(18)~~)) (19) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

((~~(19)~~)) (20) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(20)~~)) (21) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(21)~~)) (22) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(22)~~)) (23) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9. (Please update definition)

((~~(23)~~)) (24) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(24)~~)) (25) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined

in *Physicians Current Procedural Terminology,* published by the American Medical Association.

((~~(25)~~)) (26) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(26)~~)) (27) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(27)~~)) (28) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

((~~(28)~~)) (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. ****PROPOSED ADDITIONAL LANGUAGE**: A predetermination request is not a prerequisite to a request for prior authorization.**

(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.

(31) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(29)~~)) (32) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(30)~~)) (33) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(31)~~)) (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 process is prior authorization. For example, prior authorization has also been referred to as "preauthorization," "prospective review," ~~"preauthorization~~," or "precertification."

(35) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

((~~(32)~~)) (36) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

((~~(33)~~)) (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.

(38) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(34)~~)) (39) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

SUBCHAPTER D
PRIOR AUTHORIZATION AND UTILIZATION REVIEW

AMENDATORY SECTION (Amending WSR 16-11-074, filed 5/16/16, effective 1/1/17)

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

(1) These definitions apply to this section:

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

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

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

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

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

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

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

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

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

(2) Each issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a documented and transparent 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.

Commented [JP1]: It would be great to know what their methods for creating are.

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

(4) Each issuer when conducting utilization review must:

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

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

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

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

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

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

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

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

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

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

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

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

(a) Review time frames must be appropriate to the severity of the ((~~patient~~)) enrollee condition and the urgency of the need for treatment, as documented in the review request. **(**PLEASE NOTE THAT the terms "patient" and "enrollee" apparently are used interchangeably. ALSO: See definition of "emergency fill" and "immediate therapeutic needs.")**

Commented [JP2]: Please specify standard review time frames so all are held to the same turnaround times.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION

WAC 284-43-2050 Prior authorization processes.

(1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018.

(2) A carrier or its designated or contracted representative must maintain a ~~documented~~ written prior authorization program description and use medically acceptable

written 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 transparent 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. **(See language in WAC 284-43-2000(2) that states "written clinical review criteria".)**

(3) The carrier or its designated or contracted representatives 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. **(**QUESTION Is the OIC asking that prior authorization programs meet accreditation standards of all of these organizations, or just one? If just one, it would be more clear to use language such as "such as those" and then list them. Also, the organizations' full names should be utilized, rather than their initials**).** The prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) 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.

(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 have an electronic process that is browser-based

Commented [JP3]: Due to the significant amount of ongoing updates, it would be helpful to know the method for reviewing and updating.

Commented [JP4]: Want to ensure it is clear as to who's program this is referencing.

for a participating provider or facility to upload documentation and complete a prior authorization request.

(a) When a provider or facility makes a request for ~~the~~ a 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. **(**What constitutes written notice?**)**

(b) A written 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. **(**How does the provider, facility or enrollee receive notification that the prior authorization has been approved?**)**

(6) The carrier or its designated or contracted representative must have a method, consistent with the requirements of this section, that allows an out-of-network provider or facility:(a) to request a prior authorization if prior authorization is required for an out-of-network provider or facility; and (b) to be informed if there are any preservice requirements. **(**Out-of-network providers or facilities should receive the same treatment as in-network providers or facilities concerning the applicability of requirements in this subsection, in those situations where the carrier will allow payment to them. Therefore, to simply say that the carrier or its designated or contracted representative has to have a method to allow prior authorization for non-participating providers seems insufficient. As a result, we have suggested additional language. Of course, if there is some provision that should not apply, that could be spelled out. In making this recommendation,

Commented [JP5]: They should ensure there is written notification of the approval decision.

we realize that there is specific contract language concerning confidentiality and other important provisions for participating providers. However, we can envision a scenario where, when the carrier allows billing by non-participating providers, that the providers indicate their willingness to comply with relevant carrier requirements.)**

(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.

(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 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. In addition, a carrier or its designated or contracted representative must maintain normal business hours that are consistent with the time zone in which the provider or facility is located in order to facilitate communication.

(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 urgency of the need for treatment, as documented in the prior authorization request.~~ **(**This language has no meaning, as there are specific timelines set for the below.**)**

(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.

(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 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~~ business 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~~ business 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~~ business 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~~ business days of the receipt of the information or the deadline for receiving information, whichever is sooner. **(**Calendar days are unworkable, when you consider weekends. This should be changed to business days for expedited prior authorization requests. In addition, what constitutes a "day?" It is 24 hours, from 3pm on one day to 3pm**

on the next, or something else? This information could be provided in a guideline.)**

(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 stated in the enrollee's plan.

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

(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.

(15) A carrier must reimburse reasonable costs of medical record duplication for reviews. This provision cannot be waived by the provider or facility during contract negotiations with 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 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 in response to predetermination requests must clearly 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 written 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.

(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.

(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.

(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.

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.

(2) A carrier or its designated or contracted representative must allow the retrospective medical necessity review of services when an extenuating circumstance prevents a ~~participating~~ provider or facility from obtaining a required prior authorization before a service is delivered or when a prior authorization has been obtained, and extenuating circumstances prevents the provider or facility from delivering the medically necessary health care service as described in the prior authorization. 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~~ anticipate 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;

(d) The provider or facility has received a prior authorization to deliver a health care service, but extenuating circumstances prevent the service from being delivered as originally intended, to include surgical situations where the condition of the enrollee was different than what was anticipated; and

~~(d)~~ (e)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.

(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.

Commented [JP6]: Added medical necessity to ensure it is clear what they are reviewing for.

(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.