UW Medicine

August 12, 2016

Hon. Mike Kreidler
Office of Insurance Commissioner
PO Box 40258
Olympia, WA 98504-0258

RE: Prior Authorization Rulemaking – UW Medicine's Comments to Stakeholder Draft

Dear Commissioner Kreidler:

Thank you for allowing UW Medicine the opportunity to provide comments in support of your office's health insurance prior authorization rulemaking process. Your efforts to increase transparency, balance, and efficiency in prior authorization are well reflected in the first stakeholder draft of the rules. In furtherance of these efforts, UW Medicine submits the attached comments and preferred edits to the stakeholder draft. As you are aware, UW Medicine is dedicated to the fulfillment of healthcare reform's triple-aim of improved healthcare outcomes, patient satisfaction, and cost efficiency. With this dedication in mind, UW Medicine is confident that the attached comments and edits will further the triple-aim and contribute to the improvement the health, satisfaction, and purchasing power of Washington's consumers.

Thank you again for your efforts and for allowing UW Medicine the opportunity to participate in the rulemaking process.

Sincerely,

JACQUELINE L. CABE
Chief Financial Officer
UW Medicine

enclosure

UW Medicine Administration
1959 NE Pacific St Box 356350 Seattle, WA 98195-6350 206.543.7718 Fax 206.685.8767

Prior authorization processes rule (R 2016-19)

Stakeholder draft released on: July 15, 2016

For questions or comments, please contact: Jim Freeburg

Send comments to: rulesc@oic.wa.gov

Comment deadline: August 17, 2016

WAC 284-43-0160 (New definitions)

"Prior authorization" is a process that an issuer uses to determine if a health care service is a covered benefit and meets the clinical requirements for medical necessity, appropriateness, level of care, and~~or~~ effectiveness in relation to the applicable health plan. Prior authorization occurs before the service is rendered. For purposes of this rule, any term used by an issuer to describe this process is prior authorization. For example, prior authorization has also been referred to as "pre-authorization," "preauthorization," or "precertification." Prior authorization does not include Pre-determination.

"Pre-determination" is a review of benefits by issuers in order to determine whether a service which may be provided by a provider is medically necessary and/or covered under an enrollee's benefit plan.

"Standard prior authorization request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services

"Expedited prior authorization request" means any request for

Commented [LME1]: UW Medicine Comments and Preferred Edits

Commented [LME2]: The use of the word "or" in this sentence allows for multiple, inconsistent definitions of "prior authorization", varying issuer by issuer. As this would increase confusion in the prior authorization process, "or" should be changed to "and".

Commented [LME3]: Included to (a) differentiate between "prior authorization" and "pre-determination" (a different concept) and (b) allow for use of pre-determination as it is a tool/practice to increase efficiency. Many issuers currently provide "pre-determination" but not all do so.

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.

"Immediate prior authorization request" means any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of a physician with knowledge of the patient's medical condition, result in an imminent Emergency Room visit or hospital admission and deterioration of the patient's health status.

Commented [LME4]: Immediate prior authorization is a concept set forth in the Washington Healthcare Forum's "Best Practice Recommendation for Standard Notification Timeframes for Pre-Authorization Requests". (BPR) The BPR was developed by a group of representative stakeholders from the provider and issuer community.

Subchapter D – Utilization Review and Prior Authorization

WAC 284-43-2050 (New Section)

(1) Issuers must make ~~sufficient~~ information available online to participating providers or as mutually agreed to by all parties so that, prior to delivering a service, sufficient for providers ~~will be able~~ to determine whether a service is subject to prior authorization for a given enrollee. Such information must clearly and explicitly list all information required for approval of prior authorization of each specific service, including necessary supporting written documentation, if any.

Commented [LME5]: Frequently, Providers are unable to definitively determine whether a service requires prior authorization. Providers should be able to simply and clearly determine whether a service required prior authorization for a given plan.

Commented [LME6]: Frequently, issuer prior authorization requirements do not list or mention what supporting information or documents may be necessary to receive prior authorization, leaving providers short documentary or clinical information to support for a request and needing to make a supplemental submission. Listing additional necessary documentation will lead to greater efficiency for providers who can submit a complete request the first time. This would also set a more transparent standard for providers and avoid any ad hoc (unwritten) requirement changes.

(a) When a provider makes a request for ~~the~~ prior authorization, the issuer's notice approving or denying prior authorization must ~~be~~ clearly ~~and~~ explain if ~~it~~the request is

approved or denied and, where denied, include the issuer's ~~the~~ justification and basis for the decision~~,~~ (for example the prior authorization is denied because the service is a non-covered benefit), and any steps the provider may take to protest the adverse decision. Written notice of the decision must be communicated to the provider and enrollee. Such notice to the provider shall be communicated via issuer's browser-based process. The decision must include the name and credentials of the individual who had the authorizing authority to approve or deny the request. Where a provider makes a request for prior authorization for a non-covered service or a service that is considered experimental or investigational, the issuer shall deny prior authorization for that service and communicate to the provider that the requested service is non-covered, experimental and/or investigational, as applicable. (b) If a provider requests prior authorization, the provider and enrollee must be notified if the authorized facility or provider is out of network or if a requested service is considered experimental or investigational or is otherwise not covered under the enrollee's benefit plan.

Commented [LME7]: Also included in the BPR.

Commented [LME8]: UW Medicine has experienced instances where UW Medicine has asked for prior authorization of a service, unaware that the service is non-covered or considered by the issuer to be experimental/investigational. Rather than notifying that the service is not covered, in these instances issuers communicated that prior authorization is *not necessary* (but did not inform that the service is not covered), leading UW to provide the services without reimbursement.

Commented [LME9]: See above.

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

(3) In addition to other methods to process prior authorization requests, issuers that require prior authorization for procedures must have an electronic, interactive process that is user-friendly and browser-based, sufficient –to facilitate a prior authorization request, including the complete submission of any required information or documentation.

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

(5) Each issuer must have written policies and procedures to assure that prior authorization determinations are made in a timely manner.

(a) Review time frames must be appropriate to the severity of the patient condition and the urgency of the need for treatment, as documented in the prior authorization request.

(b) If the review request from the provider is not accompanied by all necessary information, the issuer must inform~~tell~~ the provider what additional information is needed and the deadline for its submission as set forth in this section.

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

Commented [LME10]: This term is not clear. What is an example of an "interactive process"?

Commented [LME11]: At times, online systems utilized by issuers lack the functional capacity to completely or efficiently carry out issuer requirements. Specifically, issuer systems at times do not allow for the complete upload of required supporting documentation, leading providers to scramble to find another way to submit materials (such as by fax). Additionally, some issuers limit the number of characters that may be typed into a prior authorization request field. Doing so limits a provider's ability to fully explain patient conditions or needs. Each of these factors requires a provider to additional steps to submit a prior authorization request, when the process should include only a single step.

Commented [LME12]: This paragraph appears to apply to "pre-determination" as opposed to prior authorization. Is this paragraph intended to describe a situation in which a provider requests prior authorization (or where a provider is requesting information as to whether a service is covered or medically necessary)? Additional clarity as to the intent of this paragraph is necessary.

Commented [LME13]: Procedures should be based upon written policies.

(a) For standard prior authorization requests:

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

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

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

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

(b) For expedited prior authorization requests:

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

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

(A) The issuer must give a provider at least ~~24~~48 hours to give the necessary information to the issuer.

Commented [LME14]: 48 hours is the BPR's recommended time frame for provider response to requests for additional information in for an Expedited ("Urgent") request.

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

(c) For immediate prior authorization requests:

(i) Where eligibility and benefits have been verified and sufficient clinical information has been provided, the issuer must make a decision and provide notification within 60 minutes, or a mutually agreeable timeframe, of receipt of the request and supporting information.

(d) Issuers shall comply with the above-listed timeframes. Where issuers do not comply and services are provided, issuers shall issue authorizations retroactive to the date of service.

(7) Prior authorization determinations shall expire no sooner than ~~45~~180 days from date of approval.

(8) Each issuer when conducting prior authorization must:

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

(b) Collect only the information necessary to authorize the health care service and maintain an efficient, user-friendly process for the provider to submit such records;

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

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

Commented [LME15]: As set forth in the BPR. Requests such as this will be infrequent but will assure reimbursement to providers who must act swiftly.

Formatted: Indent: Left: 0", First line: 0"

Commented [LME16]: This rule should specify a remedy for an issuer's failure to meet time deadlines.

Commented [LME17]: Expiration at six months is more reflective of the realities of scheduling for specialty services, which sometimes are scheduled months in advance.

authorization;

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

(f) Base review determinations solely on the medical information obtained by the issuer~~carrier~~ at the time of submission of the request for prior authorization~~the review determination~~.

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

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

Commented [LME18]: Frequently third parties retained by issuers for the purpose of carrying out prior authorization activities utilize prior authorization criteria that differ from the issuer's published criteria. This addition would better assure transparency in the prior authorization process by making clear that third parties must comply with issuer policies.

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

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

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

~~are~~ properly qualified, supervised, trained in issuer's prior authorization policies and procedures, ~~supervised,~~ and supported by explicit written clinical review criteria and review procedures. Issuers must develop and implement policies and procedures to ensure that prior authorization staff members are aware of and knowledgeable with regard to changes to issuer prior authorization policies as such changes become effective.

(14) Any Issuer change~~s~~ to a prior authorization procedure~~s~~ shall constitute~~s~~ a change to a provider contract, ~~agreement~~ as the term is used in ~~and is subject to the requirements of~~ Chapter 284-170 WAC.

(15) Issuers maintaining prior authorization policies must also maintain written pre-determination policies and procedures, and make written notifications of pre-determinations to providers within a reasonable time in response to provider requests. Issuers must, at a minimum, make pre-determinations with regard to any generic unlisted code.

Effective date: January 1, 2017.

Commented [LME19]: Frequently, issuer staff are not familiar enough with company prior authorization policies to speak knowledgably as to whether a service requires prior authorization or is covered. This leads to inaccurate (often verbal) instructions, causing services to be denied.

Commented [LME20]: See above.

Commented [LME21]: Changed to remove ambiguity. This change is necessary to more clearly convey that a prior authorization procedure change is a change to the provider contract. Original wording could be construed to mean that such changes are governed by 284-170, which allows unilateral changes upon only 60 days' notice.

Commented [LME22]: See above. Would add additional efficiency and transparency to process. Would also increase consistency among issuers.