

August 17, 2016

Ray Hsiao, MD
President

Brian Seppi, MD
Past President

Shane Macaulay, MD
President-Elect

Donna Smith, MD
1st Vice President

Tom Schaaf, MD
2nd Vice President

Bill Hirota, MD
Secretary-Treasurer

Nathan Schlicher, MD, JD
Assistant Secretary-Treasurer

Jennifer Hanscom
Executive Director/CEO

Jim Freeburg
Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Dear Mr. Freeburg:

On behalf of the Washington State Medical Association and its 10,000 physician members, thank you for the opportunity to submit comments on your “[stakeholder draft](#)” of anticipated rulemaking aimed at streamlining prior authorization processes in Washington state.

While we applaud the Office of the Insurance Commissioner (OIC) for seeking to improve patient access to care by addressing in the stakeholder draft certain aspects of administratively burdensome prior authorization processes, we are concerned over notable policy omissions and the lack of clarity around key proposals.

In this letter we have:

- Identified WSMA-supported policies that are not present in the stakeholder draft, but should be included in the final rule.
- Provided feedback on specific policy proposals from the stakeholder draft.
- Identified provisions where more clarity is needed before WSMA can provide informed comments.

Critical omissions from stakeholder draft that should be present in final rule

OIC authority under SB 5346

In 2009 the legislature passed [SB 5346](#) designed to streamline and standardize administrative interactions between issuers and providers.

SB 5346 gives the OIC clear authority to implement through rulemaking the sections of the bill that have not been voluntarily adopted by the industry to date. The WSMA is very pleased to see a number of provisions from SB 5346 included in this rulemaking. However, we urge the OIC to adopt the last remaining provision regarding extenuating circumstances:

Sec. 10(1)(a)(i): ensuring issuers do not automatically deny claims for services when extenuating circumstances make it impossible for them to obtain prior authorization before services are performed or notify issuers within 24 hours of a patient’s admission.

Appeals process

Each issuer should be required to have an appeals process for situations in which a physician disagrees with the determination of a prior authorization request. The appeal process should be completed within a timeframe considered reasonable by the OIC.

OIC proposals and WSMA comment

Definitions

OIC proposal: Defines *prior authorization* at WAC 284-43-0160 to mean “a process that an issuer uses to determine if a health care service is a covered benefit and meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan. Prior authorization occurs before the service is rendered. For purposes of this rule, any term used by an issuer to describe this process is prior authorization. For example, prior authorization has also been referred to as ‘pre-authorization,’ ‘preauthorization,’ or ‘precertification.’”

WSMA comment: Technical terminology and definitions should be consistent and clearly defined. While the WSMA supports a proposed definition of prior authorization in WAC, the WAC should also include definitions of “*standard prior authorization request*” and “*expedited prior authorization request*.” Consistent terms and phrases should be applied throughout the entire prior authorization chapter. As example, “health care services,” “medical services” and “treatment” are used interchangeably, as are the terms “physician” and “provider.” The definition above also includes the phrase “effectiveness in relation to the applicable health plan” which is unclear.

Transparency and communication requirements

OIC proposal: Requires health issuers to make sufficient information available online to participating providers (or as mutually agreed to by all parties) so that providers may determine whether a service is subject to prior authorization before submitting a request.

WSMA comment: Transparency and communication requirements are critical components for streamlining prior authorization processes, and the WSMA supports this provision.

We argue, however, that it is the OIC’s obligation to clearly define “sufficient information,” as the meaning may be very broadly interpreted.

Services not requiring a formal prior authorization request, but which are still subject to medical necessity and pre-service criteria, should also be included in the proposed online requirement.

OIC proposal: Requires health issuers to provide a clearly written notice of whether a prior authorization decision was approved or denied, including a justification for the decision.

WSMA comment: We support the inclusion of requiring a clearly written notice but are concerned by the lack of clarity around this provision. For example, the proposal states “when a provider makes a request for the prior authorization, the notice must be clear and explain if it is approved or denied.” Providers submit prior authorization requests; it is the duty of the health issuer to issue decision notices. Prior authorization is a complicated topic, and language throughout the proposed rule must be clear and concise if the process is to be streamlined for all parties.

We are also pleased to see a proposed requirement that the decision notice must include the name and credentials of the individual who had the authority to approve or deny the request. We also encourage the OIC to require issuers to provide the contact information for that authorized individual who was responsible for determining and issuing prior authorization decisions, so that physicians know who to contact to discuss the rationale for denying authorization for the requested service. This problem presents itself most frequently by issuer agents that do not make this kind of information available.

OIC proposal: Requires health issuers to notify providers and enrollees if the authorized facility or practice is out of network.

WSMA comment: We support the inclusion of this proposed communication requirement. Understanding whether a provider is in a patient's network allows patients to make informed decisions about when and where to receive the care they need.

OIC proposal: If a prior authorization request from a physician is not accompanied by all necessary information, the issuer must tell the provider what additional information is needed and the deadline for its submission.

WSMA comment: The WSMA is supportive of this proposed policy and we urge the OIC to require health issuers to clearly specify what information is missing from the request at time of notification to the provider. We urge the OIC to require that health issuers make reference to, and comply with, the "deadlines for submission" that are finalized in WAC per this rule-making, and not their own health issuer-specific deadlines.

Ability to submit a prior authorization at any time

OIC proposal: Requires health issuers to accept and process a prior authorization at any time, including outside normal business hours.

WSMA comment: The WSMA is supportive of this proposal. At the very least, reviews should be conducted during the business hours where the patient is located, not where the issuer or agent is located.

Capability to submit prior authorization requests electronically

OIC proposal: Requires health issuers to have an electronic, interactive process that is browser-based to facilitate prior authorization requests.

WSMA comment: With modern electronic medical record technology, the exchange of trusted and vetted clinical information between provider and issuer is achievable and should be the foundation of any future prior authorization process. Efforts must be focused on data exchange and associated standards that place shared accountability on both providers and issuers alike.

While requiring health issuers to provide an electronic, browser-based portal to facilitate prior authorization requests has merit as a short-term solution, the policy is shortsighted in light of recently developed clinical decision support and appropriate use criteria tools that are widely recognized as the future of prior authorization, with providers accountable for managing utilization at the point of care within existing practice workflows and processes.

If finalized, physicians and practice staff will be required to navigate away from their practice management systems and to each issuer's individual webpage, obtain log-in information and learn to operate each unique system. Our members' experience with health issuers' portals is as follows:

physicians navigate as far as they can before they are prompted to call 1-800 numbers or fax patient medical records outside of the actual portal. It is evident that these myriad portals do not comply with industry standardization intended with the passage of SB 5346.

To support this effort, we urge the OIC to require issuers to submit documentation certifying that their data and information systems support the electronic transaction standard [ASC X12N 278 HIPAA](#)ⁱ for preauthorization of health care services. Requiring all health issuers in Washington state to offer the ability to submit preauthorization requests via this electronic transaction would place Washington's healthcare system at the forefront of a solution that could truly streamline the prior authorization process and make it easier and less costly to seek approval for covered services.

Use of HIPAA standard ASC X12N 278 has the potential to allow providers and issuers to securely manage utilization at the point of care through existing practice workflows. Unfortunately, according to the CAQH (Council for Affordable Quality Healthcare), only 10 percent of health plans have adopted the standard. [CAQH](#) notes that, "given the apparent lack of adoption by health plans of fully electronic transactions to support submission of prior authorization attachments, healthcare providers may currently have no alternative to web portals and manual processes as a means of submitting prior authorizations."ⁱⁱ

The anticipated rule is a unique opportunity for the OIC to lead, and act as a catalyst for moving prior authorization into the future. We urge your office's boldness in drafting rules that incorporate emerging technologies which will reduce administrative burden for physicians and health issuers and provide better access to care for patients.

Timeliness

OIC proposal: If sufficient information has been provided, require health issuers to make prior authorization determination and decision notification within 72 hours for "standard prior authorization requests" and 24 hours for "expedited prior authorization requests."

WSMA comment: The WSMA is supportive of standardized timelines under which health issuers must process and make a decision on prior authorization requests. However, the WSMA is concerned over the absence of a definition for "sufficient information." As currently proposed, the provision gives health issuers too much latitude in determining what it means for an application to be "sufficient." This is counter to the spirit of standardization and streamlining that the OIC hopes to achieve in this rule.

Clinical criteria

OIC proposal: Health issuers must maintain a documented prior authorization program description and written clinical review criteria based on reasonable medical evidence. The program must meet national certification standards such as those used by the National Committee for Quality Assurance and have staff that are properly qualified, trained, supervised and supported by explicit written clinical review criteria and review procedures.

WSMA comment on program description and written clinical review criteria: As the stakeholder draft does not contemplate an active enforcement mechanism, we urge the OIC to require that health issuers attest, on at least an annual basis, that their prior authorization programs meet national certification standards such as those used by the National Committee for Quality Assurance.

So that physicians and issuers alike are making decisions based on the most current consensus of medical literature, issuers should be required to utilize the most recent, nationally accepted, evidence-based

appropriate use criteria or clinical guidelines produced by national specialty societies and nationally recognized utilization management organizations.

WSMA comment on staff that are properly qualified, trained, supervised: While health issuers would be required to use staff that are properly qualified, trained, supervised and supported by explicit written clinical review criteria and review procedures, the OIC does not expressly state what it means to be properly “qualified, trained and supervised.” To ensure a fair process for patients, and continued standardization, we urge the OIC to define these criteria to ensure that qualified professionals are making decisions concerning patients’ health care in Washington state.

Medical records

OIC proposal: Prohibits health issuers from routinely requesting copies of medical records, and permits access only to the portion of the medical record necessary in that specific case to certify, for the service requested, the medical necessity, appropriateness of an admission or extension of stay, and frequency or duration of service. Also, each issuer would be required to reimburse reasonable costs of medical record duplication for reviews.

WSMA comment: The WSMA supports this proposal. For continuity, we urge the OIC to use the word “determine” as opposed to “certify” medical necessity.

Issuer agents

OIC proposal: Requires health issuers to ensure that subcontractors of its contracted providers and facilities comply with the anticipated prior authorization chapter. An issuer’s obligation to comply with these requirements is non-delegable; the issuer is not exempt from these requirements because it relies on a third party vendor.

WSMA comment: The WSMA is supportive of this provision.

While we understand that the intent of the provision is to hold health issuers accountable for the actions of their contracted entities, the proposal applies to “subcontractors of its contracted providers or facilities.” In general, it is the health issuer that has these kinds of contractual relationships to conduct administrative duties, including prior authorization, not providers.

We strongly urge the OIC to clarify and revise language in this section.

Communication of new requirements to physicians and other treating providers

OIC proposal: Treats changes to prior authorization procedures as a change to provider agreement, and is subject to the requirements of Chapter 284-170 WAC.

WSMA comment: The WSMA supports this proposal.

In addition, the OIC should specifically refer to the “hold harmless” provisions at [WAC 284-170-421](#) so that health issuers and providers alike understand obligations of both parties, including: requiring issuers to provide at least 60 days’ notice to providers and facilities of changes that affect compensation or delivery of health care services; permitting providers and facilities to terminate contracts if they do not agree with changes; allowing providers to reject amendments without affecting the terms of the existing contract; prohibiting retroactive changes to contract without the express written consent of the provider or

facility; and, requiring issuers to give providers or facilities full access to the coverage and service terms of the applicable health plan for an enrolled patient.

Prior authorization expiration

OIC proposal: Prior authorization determinations do not expire for 45 days following the date of approval.

WSMA comment: The WSMA supports standardizing expiration dates across issuers. As some physician specialties have long lead times for scheduling services, the WSMA recommends expanding the expiration to 90 days following date of approval.

Provisions in the preproposal draft requiring additional clarification or explanation

OIC proposal: Requires issuers to have written procedures to assure that prior authorization determinations are made in a timely manner.

WSMA comment: The intent of this section is unclear. While having written procedures sounds like those would be helpful to physicians seeking to understand a health issuer's prior authorization processes, there is no explanation of what such written procedures would necessarily address. There is also no explanation of what it means to process a request in a "timely manner"- this is too open to interpretation.

In addition, the subsection on review timeframes is already considered in the "time frame" section of the stakeholder draft, and the requirement that issuers tell providers what information is missing from their request is considered in the notification section previously discussed.

While there is the potential for written procedures to be helpful to providers and patients, this concept needs to be further developed for it to have any real-world utility.

OIC proposal: 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.

WSMA comment: The intent of this provision is unclear. It is also unclear why this provision only applies to "specialists," as opposed to all physicians and other providers. We encourage the OIC to clarify this proposal's intent.

OIC proposal: Requires health issuers to accept information from any reasonably reliable source that will assist in the authorization process, collect only information necessary to authorize the health care service and maintain a process for the provider to submit records, and prohibits issuers from routinely requiring providers or facilities to numerically code diagnosis or procedures to be considered for authorization, but may request such codes, if available.

WSMA comment: While the WSMA is supportive of efforts to reduce administrative burden on physicians and other providers, these topics appear to be addressed in other portions of the stakeholder draft. If these are not, then these provisions require additional clarity around the OIC's intent before the WSMA can provide helpful feedback.

In addition, not only is permitting issuers to accept information from "any reasonably reliable source that will assist in the authorization process" a vague standard, but it is also undefined and could have unclear and troubling consequences. Issuers should be required to utilize the most recent, nationally accepted,

evidence-based appropriate-use criteria or clinical guidelines produced by national specialty societies and nationally recognized utilization management organizations. Health issuers should be required to attest to meeting such prior authorization program requirements on an annual basis.

OIC proposal: When an enrollee must change plans due to an issuer's market withdrawal, the patient's new issuer must recognize the prior authorization of the previous issuer, and ensure that the enrollee receive the services that were previously authorized as an in-network covered service.

WSMA comment: The WSMA is strongly supportive of efforts to ensure continuity of care for patients that are forced to change insurance plans due to an issuer's market withdrawal. We have concerns, however, about the operational feasibility of this provision. More information and clarity is required for the WSMA to understand how the OIC envisions this requirement to be implemented effectively.

Additional omissions from stakeholder draft that should be present in final rule

Prohibit retroactive denial of covered, medically necessary services

The WSMA urges the OIC to promulgate rules for section [RCW 48.43.525](#), which requires a “prohibition against retrospective denial of health plan coverage.” While the RCW language is explicit in its prohibition of retroactive denials, health issuers routinely deny coverage for service after they have been provided. RCW 48.43.525 calls on the Commissioner to adopt rules for standards, however, it is our understanding that these standards were never promulgated. The OIC should ensure that once a prior authorization has been secured, a health issuer is not able to retroactively deny coverage for a service, promulgating rules for section RCW 48.43.525.

The presumed availability of coverage for a particular service, based on that prior authorization, directly influences the course of treatment agreed upon by the patient and the provider. When health issuers retroactively rescind a prior authorization, patients can be left bearing the financial responsibility for services provided to them by physicians and other providers that were understood to be approved and should otherwise be covered under the health plan.

Prohibit retroactive denial of covered, medically necessary services provided intraoperatively
Surgeons can request prior authorization for a specific procedure and receive the approval. However, during the actual surgery, the surgeon may discover that an alternative surgical procedure is clinically necessary. As an example, one physician recently noted that during surgery for a vestibular stenosis repair, he had to harvest auricular cartilage because the patient did not have enough septal cartilage. Even though the report clearly documented medical necessity, and that the decision to harvest a different kind of cartilage was made intraoperatively, the service was denied retroactively.

In instances like these, issuers deny payment for the procedure performed as it differs from the procedure initially authorized, and do not typically allow for retroactive corrections to these situations.

Such denials are not unique to surgery. A primary care provider (PCP) may request an imaging study, and can provide a CPT code as part of the prior authorization request. The radiologist may decide, appropriately, that a different study, rather than the one ordered by the PCP, be performed and that alternative study can have a different CPT code than what was initially stated.

Issuers typically do not offer any latitude in this difference, nor will they offer retroactive correction to this difference in codes. Such denials should be prohibited.

Enforcement

We recommend that the OIC develop an active enforcement mechanism and standards in order to ensure best application of the rules. Going forward, we need the establishment of uniform standards and monetary penalties for failure to comply.

The WSMA applauds the OIC for seeking to improve patient access to care by addressing administratively burdensome prior authorization processes in Washington state. If finalized as proposed (with necessary clarifications), this stakeholder draft would be a strong step in the right direction of making sure consumers of health care have access to the services they purchased and physicians are not unduly burdened in providing that care.

We appreciate your consideration of these comments. For questions, please do not hesitate to contact Jeb Shepard at jeb@wsma.org.

Sincerely,



Jennifer Hanscom, Executive Director/CEO

cc: WSMA Executive Committee
Kathryn Kolan, JD, Director, Legislative and Regulatory Affairs

ⁱ www.caqh.org/core/operating-rules-mandate

ⁱⁱ www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf