Memorandum

To: OIC Rules Coordinator rulesc@oic.wa.gov
From: Annie LaCroix, LMP, President, American Massage Therapy Association, Washington Chapter
Re: OIC Stakeholder Draft on Prior Authorization dated September 23, 2016
Date: October 14, 2016

The following comments are submitted on behalf of the American Massage Therapy Association, Washington Chapter (AMTA-WA), a statewide organization representing over 5,000 licensed massage practitioners. AMTA-WA appreciates the opportunity to respond to the September 23rd OIC draft on prior authorization.

AMTA-WA thanks the OIC for its commitment to streamlining and standardizing prior authorization procedures, so that health care consumers are not denied appropriate health care. And while AMTA-WA believes that a great deal of progress has been made concerning these rules, we believe the OIC, as well as stakeholders, would benefit from the opportunity to review another version of draft rules before the CR-102 is filed.

The following are our comments:

1. Medical necessity. In our opinion, these words are used frequently to deny health care consumers access to medically necessary services. In the massage profession, we often receive referrals from primary care providers that include a certain number recommended sessions. Most carriers are unwilling to approve what the prescribing physician has ordered citing "medical necessity." But the rationale is never really given. We are hopeful that requirements in these rules to require "plain talk" concerning denials will be helpful. Also, currently, the enrollee is notified by mail, this can take up to two weeks, as mail delivery has considerably slowed. It's important to remember that not all enrollees or providers have e-mail or fax services. We recommend certified 2-day mail where electronic notice is not available.

a. An additional issue to consider concerning denials. Carriers should also be required to explain in "plain talk" their rationale for approving fewer than the prescribed number of visits. We would suggest the following amendment to WAC 284-43-2050(5)(a):

"(a) When a provider makes a request for the prior authorization, the response from the carrier or their 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 criteria for the denial. A denial includes a decision by the carrier to not authorize what was requested in a prior authorization in whole or in part. The response must give the true and actual reason in clear and simple language so that the enrollee and the provider will not need to resort to additional research to understand the real reason for the action. Written notice by fax, e-mail, or certified 2-day mail, where electronic formal is not available, of the decision must be communicated to the provider or facility, and the enrollee. 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.

2. Length of time a prior authorization is effective. Currently the rules state that a prior authorization is effective for 45 days. We believe that should be extended to 90 days. Our rationale is that because of the trend toward smaller and smaller panel sizes, it is often difficult to schedule an appointment for a massage within 30 days in some locations, such as Thurston County. Then, if the prior authorization is for four or so sessions, one or two weeks apart, you can see how quickly the time evaporates. And yes, once the timeline is passed, a massage therapist can submit another prior authorization, but this takes time and disrupts the flow of care, with the very real potential of increasing overall health care costs when a patient's progress is set back because of unnecessary delays. Extending the "life" of a prior authorization to 90 days would help alleviate these problems.

3. Record copying. In at least two places in the draft rules, there are requirements for carriers to reimburse providers for the cost of copying enrollee records, once of which is current language. However, provider contracts with carriers current prohibit providers from being reimbursed for these costs. We would expect that after these rules are adopted, that carriers would be reminded that their provider contracts need to be in conformance with the rules.

4. Non-participating providers. While the wording in the proposed WACs simply says "provider" and not "participating provider", we would very much appreciate language that makes it clear that non-participating providers who bill carriers for health care services can have access to carriers' web pages in order to determine prior authorization and other requirements. Currently, this is not the case for some insurers.