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October 14, 2016

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 over 10,000 members, thank you for the opportunity to submit comments on the second “[stakeholder draft](#)” of anticipated rulemaking aimed at streamlining and standardizing prior authorization processes in Washington state.

We applaud the Office of the Insurance Commissioner (OIC) for seeking to improve patient access to medically necessary care by addressing in the stakeholder draft certain aspects of administratively burdensome prior authorization processes.

In this letter we have:

- Recognized critical provisions from SB 5346 included in the stakeholder draft.
- 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.

Enclosed in this communication, the WSMA has provided specific technical and policy edit suggestions (underlined in red, comments in blue) to the OIC’s draft language. You will find those recommendations at the end of this letter.

Provisions of SB 5346 included in stakeholder draft

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 pleased to see key provisions from SB 5346 included in this rulemaking, including:

Extenuating circumstances

OIC proposal: Requires health issuers and their contracted agents to allow the retrospective review of services when an extenuating circumstance prevents a provider from obtaining a required prior authorization before a service is delivered. An extenuating circumstance is one where an issuer must not deny a provider’s claim for lack of prior authorization if the services are otherwise eligible for reimbursement. At a minimum, the health issuer’s policy must address:

- A provider is unable to expect the need for the outpatient service in question prior to performing the service;
- The provider is unable to know which issuer or their designated or contracted representative to request prior authorization from; and
- The provider does not have enough time to request a prior authorization

WSMA comment: The WSMA is supportive of this provision and applauds its inclusion in the most recent stakeholder draft. However, we request clarification around why the situation listed in subsection (a) is limited to the outpatient setting. The word “outpatient” should be removed, so that is applicable to all health services, regardless of setting.

In addition, we request that the OIC specifically include medically necessary services provided intraoperatively in the list of requirements for an extenuating circumstances policy. Such language might look like the following:

(d) A provider performing a service decides, appropriately, that a different service rather than the initially approved service is required, such as 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 reported 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 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 appropriate latitude in the authorization process that reflects the clinical realities in such 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 in the prior authorization request.

Issuers typically do not offer any latitude in this difference, nor will they offer retroactive correction to this difference in codes. The current proposed language for the OIC’s extenuating circumstances policy, and current policy around retroactive denials, is not strong enough to prohibit these kinds of patently unfair denials, and the OIC should be clear in their prohibition of such unfair actions by issuers.

Capability to submit prior authorization requests electronically

OIC proposal: Requires health issuers and their contracted entities to have an electronic, interactive process that is browser-based to complete 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 should be focused on data exchange and associated standards (such as [ASC X12N 278 HIPAA](#)) that would allow for a patient-centric model of prior authorization, and place shared accountability for utilization management 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. The OIC's proposal, if adopted, would require physicians and practice staff 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.

The WSMA is pleased, however, to see the inclusion in this stakeholder draft, a requirement that the browser-based process be able to "complete" a prior authorization request, as opposed to merely "facilitate." This change would help to address the current reality of web portals, whereby 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.

Timeliness

OIC proposal: Requires health issuers and their contracted agents to have written policies to assure that prior authorization determinations are made within appropriate timeframes for the following:

- Immediate prior authorization requests: within 60 minutes (or as stated in the provider contract) after benefits have been verified and sufficient clinical information has been provided to the health issuer.
- Standard prior authorization requests: 5 calendar days after benefits have been verified and sufficient clinical information has been provided to the health issuer.
- Expedited prior authorization requests: 48 hours after benefits have been verified and sufficient clinical information has been provided to the health issuer.

WSMA comment: The WSMA is supportive of the standardized timelines under which health issuers must process and make a decision on prior authorization requests proposed in the previous stakeholder draft: 72 hours for *standard prior authorization requests* and 24 hours for *expedited prior authorization requests*.

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.

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

Clinical criteria in lieu of prior authorization, where appropriate

OIC proposal: Health issuers and their contracted agents must maintain a documented prior authorization program description and written clinical review criteria based on reasonable medical evidence that is consistent with clinical guidelines produced by national specialty societies. The program must meet national certification standards such as those used by the National Committee for Quality Assurance (NCQA). Any evidence-based information a provider submits to assist in the authorization process must be accepted by the health issuer.

WSMA comment: The WSMA is supportive of requirements that ensure health issuers are making decisions based on the most current consensus of medical literature.

When a provider can demonstrate, however, that they are utilizing nationally accepted, evidence-based appropriate use criteria or clinical guidelines produced by national specialty societies and nationally recognized utilization management organizations, prior authorizations should not be required.

In addition, health issuers should be required to list which national certification standards (NCQA or otherwise) their prior authorization program meets in the “online prior authorization system” contemplated in subchapter D of the stakeholder draft.

Prohibit retroactive denial of covered, medically necessary services

The WSMA urges the OIC to promulgate rules for section [RCW 48.43.525](#). 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, by 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.

OIC proposals and WSMA comment

Definitions

OIC proposal: Defines the terms *expedited prior authorization request*, *immediate prior authorization request*, *pre-determination request*, *pre-service requirement*, *prior authorization*, *standard prior authorization* at WAC 284-43-0160.

WSMA comment: The WSMA supports definitions of *prior authorization* in WAC, and is pleased to see the definitions of *expedited prior authorization request*, *pre-determination request*, *pre-service requirement*, *standard prior authorization* and *immediate prior authorization* included in this stakeholder draft.

As discussed at the OIC’s October 5th stakeholder meeting, there is confusion regarding the circumstances in which these different kinds of prior authorization should be utilized. We urge the OIC to clarify these situations with examples.

Under the definition of *prior authorization*, please strike the word “mandatory.” The language suggests that prior authorization would be a required process for all services should the OIC finalize this proposed definition.

While we applaud the inclusion of a *pre-determination request*, we urge the OIC to include any pre-service requirements included in addition to information about whether or not the service is a covered benefit.

While technical terminology is much improved in this draft, consistent terms and phrases should be applied throughout the entire prior authorization chapter. As an example, “health care services,” and “treatment” are still used interchangeably. In addition, “health carrier” as well as “issuer” are used, and

there are numerous instances where “provider” is included, but not “facility.” The definition of *prior authorization* also still includes the phrase “effectiveness in relation to the applicable health plan” which remains unclear to the WSMA.

Transparency and communication requirements

OIC proposal: Requires health issuers and their contracted entities to have a “current and accurate” online prior authorization system that is accessible to providers and facilities for the purposes of determining if a service is a covered benefit under the enrollee’s health benefit plan and the information necessary to submit a complete a prior authorization request before delivering a service. Specifically, the online system must include sufficient information to determine:

- If a service is a covered benefit under the enrollee’s health benefit plan;
- If a prior authorization request is necessary;
- If any preservice requirements apply; and
- If a prior authorization request is necessary, the following information:
 - The clinical criteria used to evaluate the request; and
 - Any required documentation.

WSMA comment: Transparency and communication requirements are critical components for streamlining prior authorization processes. We urge the OIC to strengthen this provision by clarifying that patient-specific formularies and benefit plans are to be made available by inputting a patient’s plan identification number.

In addition, it is the OIC’s obligation to clearly define “sufficient information,” as the meaning may be very broadly interpreted.

We applaud the OIC for including services not requiring a formal prior authorization request, but which are still subject to medical necessity and pre-service criteria in this draft.

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, including criteria for the denial. Written notice of the decision must be communicated to the provider or facility and the enrollee in clear and simple language.

WSMA comment: We support the inclusion of requiring a clear, simply written notice of whether a prior authorization decision was approved or denied and the basis for that decision.

We are also pleased to see a proposed requirement that a decision notice must include a phone number to contact the authorizing authority (so that physicians know who to contact to discuss the rationale for denying authorization for the requested service) and notice regarding the patient’s appeal rights.

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.

We are supportive of the OIC's proposal to require health issuers to state whether the authorized service may be delivered by an out of network provider or facility, and disclose to the enrollee the financial implications for receiving care from an out of network provider.

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.

OIC proposal: Requires health issuers and their contracted agents to maintain a system of documenting information and supporting evidence submitted by providers and facilities while documenting prior authorization. Upon request, health issuers or their contracted agents must remit written acknowledgement of receiving of each document submitted in support of a prior authorization request. When information is transmitted over the telephone, health issuers and their contracted agents must provide written acknowledgement of the information communicated by the provider.

WSMA comment: The WSMA is supportive of policies that reduce administrative burden on providers by requiring health issuers and their agents to track what kind of information has been submitted in relation to a prior authorization request, and making that information available to providers upon request.

Ability to submit a prior authorization at any time

OIC proposal: Requires health issuers or their contracted agent to accept 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. Should the OIC adopt this recommendation, we would urge the OIC to require health issuers to begin processing (as opposed to merely accepting) a prior authorization within the business hours where the patient is located, especially for immediate and expedited prior authorization requests.

Insufficient information

OIC proposal: If sufficient information has not been provided to the health issuer or contracted agent to make a decision for:

- Standard prior authorization requests: health issuers or contracted agents have 5 calendar days to request additional information from the provider. The provider then has 5 calendar days to submit necessary information.
- Expedited prior authorization requests: health issuers or contracted agents have 24 hours to request additional information from the provider. The provider then has 48 hours to submit necessary information.

WSMA comment: Requiring providers to respond within a set number of hours or calendar days is problematic, as many medical practices are closed on Saturday and/or Sunday, and up to three days for holiday weekends. As example, if a provider were to submit a request on Friday morning and the issuer responded that the information was incomplete Friday evening, the 48-hour clock would have started and ended before the provider even returns to the office. Once the physician receives the notification from the

health issuer, they must often review medical records, confer with other members of the care team, and circle back with the patient to collect relevant information. We recommend requiring physicians to respond with additional information within a set number of business days as opposed to hours or calendar days in order to allow the practitioner an appropriate amount of time to collect information.

Appeals process

OIC proposal: Prior authorization denials are an adverse benefit determination and is subject to the appeal process.

WSMA comment: An appeals process is a critical avenue for providers and patients to obtain authorization for a covered, medically necessary service after it was initially denied. Please clarify which appeals process the OIC refers to in this instance.

Prior authorization program

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 NCQA 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 list which national certification standards (NCQA or otherwise) their prior authorization program meets in the “online prior authorization system” contemplated in Subchapter D of the stakeholder draft.

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.

Issuer agents

OIC proposal: Clarifies that 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 or subcontracting arrangement for its prior authorization program.

WSMA comment: The WSMA is supportive of this provision.

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 and facilities full access to the coverage and service terms of the applicable health plan for an enrolled patient.

Per the October 5th stakeholder meeting, we suggest not referring to prior authorization as a “procedure”, and request additional clarity around what constitutes a change (i.e. clinical criteria vs. administrative, etc.)

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.

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 (for up to 30 days or the expiration of the authorization, whichever is longer), and ensure that the enrollee receive the services that were previously authorized as an in-network covered service.

WSMA comment: The WSMA is supportive of efforts to ensure continuity of care for patients that are forced to change insurance plans due to an issuer’s market withdrawal.

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: It was explained at the October 5th stakeholder meeting that this provision seeks to address situations where a patient may be required to travel substantial distances to see a specialist, only to receive a required preservice consult and be sent home, to return again (over great distances) for the actual service. The WSMA is supportive of this provision that seeks to relieve travel and other kinds of

burdens on patients by allowing specialists to order services in advance of seeing a patient, upon review of the medical record.

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

WAC 284-43-0160 (New definitions)

“Expedited prior authorization request” means any request by a provider or facility for approval of a health care 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 with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the ~~care or treatment~~ health care service that is the subject of the request.

“Immediate prior authorization request” means any request by a provider of facility for approval of ~~treatment a~~ health care service where the passage of time without receiving that service ~~treatment~~ would, in the judgement of the provider, result in an imminent emergency room visit or hospital admission, and deterioration of the enrollee's health status. Immediate prior authorization requests ~~includes~~ include “urgent prior authorization requests.” (There is no definition of “urgent prior authorization requests” and in fact these words are not used in this draft. The words “urgent care review request” are found in WAC 284-43-2000, but are deleted. That definition is substantially similar to “expedited prior authorization request.”)

“Pre-determination request” means a voluntary request from an enrollee, provider, or facility for a carrier or ~~their~~ its designated or contracted representative to determine if a health care service is a covered ~~benefit~~ health condition and medically necessary in relation to the applicable health plan or any request related to the site of health care service/place of health care service. (The definition is “covered health condition” not “covered benefit.” More significantly, it's important to include facilities.)

“Pre-service 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 ~~rendering~~ provider delivering the health care service, site of health care service/place of health care service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.

“Prior authorization” is a ~~mandatory~~ process that a carrier or ~~their~~ its designated or contracted representative requires a provider or facility to follow to determine if a health care service is a covered benefit and meets the clinical requirements for medical necessity, ~~appropriateness, level of care, and effectiveness~~ in relation to the applicable health plan. Prior authorization occurs before the service is ~~rendered~~ delivered. For purposes of this ~~rule~~ definition, any term used by a carrier or ~~their~~ its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as “~~pre-authorization~~,” “prospective review,” “preauthorization,” or “precertification.” (There is no need to list pre-authorization twice, once with a hyphen, once without. More significantly, it is confusing to state “medical necessity” and then include other language such as “appropriateness, level of care, and effectiveness.” Aren't these already components of “medical necessity? The term “covered health condition” is defined, but it seems more awkward to use those words, rather than “covered benefit” in this definition, as well as throughout these rules.)

“Standard prior authorization request” means any request by a provider or facility for approval of a health care service where the request is made in advance of the enrollee obtaining ~~medical~~ health care ~~or~~ services.

Subchapter D – Utilization Review and Prior Authorization

WAC 284-43-2050 Prior authorization processes (New section)

(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. (The definition of “health benefit plans” in RCW 48.43.005 is almost identical to the definition of “health plan” or “plan” found in WAC chapter 284-43. But since it's not identical, it is confusing.)

(2) Each carrier or ~~their~~ its designated or contracted representative must maintain a ~~documented~~ written prior authorization program description that is posted on its web page and use medically acceptable ~~screening~~ clinical review criteria. Carriers or their designated or contracted representatives must make determinations in accordance with ~~currently acceptable~~ current clinical review criteria ~~medical or health care practices~~. The program must include a method for reviewing and updating criteria. A carrier or ~~their~~ its designated or contracted representative must not use ~~medical evidence or standards~~ clinical review criteria in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care. (The term “clinical review criteria” is defined, and therefore should be used.)

(3) The prior authorization program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance in addition to the requirements of this chapter. The prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) Carriers or their designated or contracted representatives must have a current and accurate online prior authorization system. The online system must be accessible to providers and facilities so that, prior to delivering a health care service, providers and facilities will have enough information to determine if a health care service is a covered benefit or any questions related to the coverage of a facility under the enrollee’s health ~~benefit~~ 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 health plan: (There are multiple variations in definitions between WAC Chapter 284-43 and RCW 48.43.005. For example, it’s “health plan or plan” under the WAC chapter, but it’s “health benefit plan or health plan” under the RCW. Using “health plan” covers both bases, but at some point the OIC may want to review all of its definitions in statute and WAC to be sure they are in sync.)

- (a) If a health care service a covered benefit ~~under the enrollee’s health benefit plan~~;
- (b) If a health care facility is covered as the site of delivery of the health care service;
- (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, carriers or their designated or contracted representatives that require prior authorization for services must have an electronic, interactive process that is browser-based to complete a prior authorization request.

(a) When a provider or facility makes a request for the prior authorization, the response from the carrier or ~~their~~ 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 any~~ 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 (please delineate what forms are acceptable) of the decision must be communicated to the provider or facility, and the enrollee. ~~The A~~ 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.

(b) A prior authorization approval notification 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 yes, disclose to the enrollee the financial implications for receiving services from an out of network provider or facility.

(6) Carriers or their designated or contracted representative are responsible for maintaining a system of documenting information and supporting evidence submitted by providers and facilities while requesting prior authorization.

(a) Upon request of the provider or facility, carriers or their designated or contracted representative~~s~~ must ~~remit~~ provide to the provider or facility written acknowledgement of receipt of each document submitted by a provider or facility during the processing of a prior authorization request. (Please list acceptable forms of written acknowledgment)

(b) When information is transmitted telephonically, the carrier or ~~their~~ its designated or contracted representative must provide written acknowledgement of the information communicated by the provider or facility. (Please list acceptable forms of written acknowledgment)

(7) Carriers or their designated or contracted representative~~s~~ that require prior authorization for any covered health care service must accept a prior authorization request from providers and facilities at any time, including outside normal business hours.

(8) Each carrier or ~~their~~ its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations are made within the appropriate timeframes delineated in this rule.

(a) Time frames must be appropriate to the severity of the enrollee condition and the urgency of the need for health care services ~~treatment~~, as documented in the prior authorization request.

(b) If the request from the provider or facility is not accompanied by all necessary information, the carrier or ~~their~~ 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.

(9) The time frames for carrier or ~~their~~ its designated or contracted representative prior authorization determination and notification are as follows:

(a) For immediate prior authorization requests: (i) Within 60 minutes, ~~or as stated in the provider contract~~, after eligibility and benefits have been verified and sufficient clinical information has been provided to the health plan. (In order assure standardization, a provider contract, over which many providers have very a limited ability to influence, should not be allowed to override the provisions of these rules.)

(b) For standard prior authorization requests:

(i) If sufficient information has been provided to the carrier or ~~their~~ its designated or contracted representative to make a decision, the carrier or ~~their~~ its designated or contracted representative has 5 calendar days once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier or ~~their~~ its designated or contracted representative has 5 calendar days to request additional information from the provider or facility.

(A) The carrier or ~~their~~ its designated or contracted representative must give a provider or facility 5 calendar days to give the necessary information to the carrier or their designated or contracted representative.

(B) The carrier or ~~their~~ its designated or contracted representative must then make a decision and give notification within 4 calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(c) For expedited prior authorization requests: (These timelines are problematic for both carriers and providers. As a result, we are suggesting business days instead of a number of hours.)

(i) If sufficient information has been provided to the carrier or ~~their~~ its designated or contracted representative to make a decision, the carrier has ~~48 hours~~ two business days once the information has been received to make a determination and provide notification.

(ii) If insufficient information has been provided to the carrier or their designated or contracted representative to make a decision, the carrier or ~~their~~ its designated or contracted representative has ~~24 hours~~ one business day to request additional information from the provider.

(A) The carrier or ~~their~~ its designated or contracted representative must give a provider or facility ~~48 hours~~ two business days to give the necessary information to the carrier or their designated or contracted representative.

(B) The carrier or ~~their~~ its designated or contracted representative must then make a decision and give notification within ~~48 hours~~ two business days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(10) Immediate prior authorization requests do not include the following situations:

(a) The health care service being requested had been pre-scheduled, ~~was~~ was not an emergency when scheduled, and no change in ~~patient~~ enrollee condition has occurred;

(b) The request is for experimental or investigational health care services or a clinical trial;

(c) The request is for the convenience of the ~~patient's~~ enrollee's schedule or provider's schedule-; and

(d) The results of the requested health care service are not likely to lead to an immediate change in the ~~patient's~~ enrollee's ~~treatment~~ condition??

Subsection (10) above should be relocated to the definition so that it makes more sense.

(11) Each carrier or ~~their~~ 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 prior authorization process;

(b) Collect only the information necessary to authorize the health care service and maintain a process for the provider or facility to submit such records;

(c) Not routinely request copies of medical records to render prior authorization;

(d) If medical records are requested, Require ~~require~~ only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the health care service to be delivered, to include admission or extension of stay, frequency or duration of service;

(e) 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

(f) Use the medical necessity definition stated in the enrollee's health benefit plan.

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

(13) Prior authorization determinations shall expire no sooner than ~~45~~ 90 days from date of approval. This requirement does not supersede RCW 48.43.039. (Because of narrowing panels of providers, many providers, to include specialists as well as those associated with the various therapies, can have long wait times for initial appointments. Sometimes a prior authorization is for one specific service, sometimes, as with the therapies, it's for a series of services. Because of these factors, 90 days is more reasonable, and cost effective for both carriers and providers, as it will lessen the need to re-apply for prior authorization simply because the 45 day period has expired.)

(14) Each carrier must reimburse reasonable costs of medical record duplication for reviews.

(15) A carrier's obligation to comply with prior authorization requirements is non-delegable. The carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program.

(16) In limited circumstances when enrollees have 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), subsequent carriers or their designated or contracted representative must recognize the prior authorization of the previous carrier and ensure that the enrollee receives the initial service that was previously authorized as an in-network covered service. Carriers or their designated or contracted representative must recognize the prior authorization for at least 30 days or the expiration date of the original prior authorization, whichever is greater. ~~Enrollee's~~ Enrollees must present proof of the prior authorization.

(17) Pre-determination notices must clearly disclose to the requesting provider or facility, and enrollee that the determination is not a prior authorization and does not guarantee services will be covered.

(18) Any carrier changes to a prior authorization procedure constitute a change to a provider contract as the term is used in Chapter 284-170 WAC and must be made as an amendment.

(19) 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 ~~their~~ its designated or contracted representative at the time of the prior authorization request.

(20) Carriers or their designated or contracted representatives must have a prior authorization process that allows ~~specialists~~ health care providers 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.

WAC 284-43-2060 Extenuating circumstances (New section) (While this section is a step in the right direction, it misses an important component. What's missing is that it does not impact those situations where a prior authorization has been granted, but unforeseen circumstances require that the provider modify the procedure. As a result, some carriers will simply deny the entire claim when any type of correction or update is made.

(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. (The definition of "health benefit plans" is almost identical to the definition of "health plan" or "plan" found in WAC chapter 284-43. But since it's not identical, it is confusing.)

(2) Carriers or their designated or contracted representatives must allow the retrospective review of services when an extenuating circumstance prevents a provider or facility from obtaining a required prior authorization before a health care service is delivered or when a prior authorization has been obtained, an extenuating circumstance prevents the provider or facility from delivering the care as described in the prior authorization. For purposes of this section, an extenuating circumstance means a situation where a carrier or its designated or contracted representative must not deny a provider's or facility's claim for lack of prior authorization or for submitting a claim that is different than the health care service authorized, due to unforeseen circumstances, if the services are otherwise eligible for reimbursement. The carrier's or ~~their~~ 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~~ health care service in question prior to performing the service; (It should apply to outpatient and inpatient.)

(b) The provider or facility is unable to know which carrier or ~~their~~ its designated or contracted representative to request prior authorization from; and

(c) The provider does not have enough time to request a prior authorization or ask for a modification to a prior authorization; or

(d) A provider performing a service decides, appropriately, that a different service rather than the initially approved service is required, such as medically necessary services provided intraoperatively.

(3) A carrier or ~~their~~ its designated or contracted representative may require providers and facilities to follow certain procedures in order for services to qualify as an extenuating circumstance, such as requirements for documentation or a timeframe for claims submission or modification. Claims related to an extenuating circumstance may still be reviewed for medical necessity.

(4) This section does not apply to services covered under an enrollee's pharmacy benefit.

WAC 284-43-2000 Health care services utilization review—Generally. This WAC is confusing and needs a thorough review. As amended, it's too confusing.)

(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.

(e) "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 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. (This language was used as a template for proposed WAC 284-43-2050(2), but the language is not identical. And should there be some language in this WAC to clarify that the topic of prior authorization is covered in the other WACs. Bottom line, this stand-alone WAC is confusing given the proposed adopted of the new WACs related to prior authorization.)

(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; (This isn't included in proposed WAC on prior authorization. Is there a reason?)

(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; (what does prospective review refer to? And note that you deleted "prospective review below")

(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 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; (It is potentially confusing to have some portions of prior authorization in this WAC, and some in the others.)

(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 condition and the urgency of the need for treatment, as documented in the review request.

(b) If the review request from the provider or facility is not accompanied by all necessary information, the issuer must tell the provider 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; (There is no longer a definition for an urgent care review request...see deletes below, made by the OIC.)

~~(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 (**what type of request**) was approved or denied must be made available to the attending ~~physician, ordering~~ provider, 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 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.