Memorandum

To: OIC Rules Coordinator

From: Gail McGaffick for the Washington State Podiatric Medical Association

Re: OIC Stakeholder Draft on Prior Authorization dated September 23, 2016

Date: October 14, 2016

The following comments are submitted on behalf of the Washington State Podiatric Medical Association (WSPMA), a statewide organization representing podiatric physicians and surgeons. WSPMA appreciates the opportunity to respond to the September 23rd draft, as well as participate in the recently held OIC stakeholder meeting on this topic.

WSPMA thanks the OIC for its commitment to streamlining and standardizing prior authorization procedures, so that health care consumers are able to receive appropriate health care. And while WSPMA believes that a great deal of progress has been made concerning these rules, we believe there is still some important work that remains to be done, as you will note from our suggested edits. For that reason*, we believe it is very important that stakeholders be given an additional opportunity to review a draft prior to the CR-102 being filed*.

In addition to endorsing the written comments submitted by the Washington State Medical Association, WSPMA has made the following detailed comments embedded in the draft rules. In our collaborative work with WSMA, we know that they also included virtually all of the editing comments noted below in their OIC comments. The differences are some additional technical edits. Further, WSMA and WSPMA have slightly different approaches to our concerns surrounding the subject of extenuating circumstances. We have the same goals, but writing the language to reflect those goals was challenging. As a result, you have two options, that are somewhat different, for your consideration.

Edits are made in red ink and underlined, while comments in the form of rationales or questions are in blue ink.

WSPMA would like to highlight several points before we begin:

- Prohibit retroactive denial of covered, medically necessary services. As you know from multiple letters, providers did not remember that there was a statute on the books prohibiting retroactive denials…because there were so many denials. The statute (RCW 48.43.525) directs the OIC to write rules, but this has never been done. In the short term, a statement should be included in these rules reminding insurers that the statute exists. In addition, the OIC needs to fulfill the statutory mandate.
- Enforcement. While there is no specific enforcement mechanism contained in these draft rules, we know that the OIC relies on complaints from health care consumers and providers to indicate when there are problems. From time to time, I've had the sense that OIC believes that complaints from consumers are more important than those from providers. Perhaps, this is no longer true. In making these comments, WSPMA asks the OIC to understand that it is the providers who notice patterns of problems, and more importantly, are advocates for their patients when their patients' health challenges prevent them from taking the time to file a complaint.

WAC 284-43-0160 (New definitions) Changes are made throughout the draft to reflect the definitions found in this existing WAC.

"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. (The definition in this existing WAC section is "health care service" or "health service")

"Immediate prior authorization request" means any request by a provider or 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 or facility, 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." (The words "urgent care review request" are found in WAC 284-43-2000, but are deleted. And that definition is substantially similar to "expedited prior authorization request." So, this is very confusing.)

"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 health care 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~~ health condition 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, and while it seems more awkward to use those words, rather than "covered benefit" in these rules, it is the definition. If you agree, we recommend a word search for the word "covered" as multiple changes will need to be made.)

"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. (How will the OIC verify that the requirements of this subsection are being met?)

(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 is 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. (It's simpler to delete "for services" rather than also explain the facility components of prior authorization. By removing "for services" the sentence covers all the bases.)

(a) When a provider or facility makes a request for ~~the~~ a 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 health care service may be delivered by an out of network provider or facility and if yes, disclose to the enrollee the financial implications for receiving health care services from an out of network provider or facility.

(6) Carriers or their designated or contracted representatives 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 representatives 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 representatives 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. (We know that there has been push back from carriers on this. At a minimum, prior authorization requests should be accepted during normal business hours in the time zone in which the enrollee is located.)

(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. (We know that the OIC is including some of the information in WAC 284-43-2000. But, since the time frames are already delineated below, is this subsection needed?)

(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 to 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~~ its 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 or facility.

(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~~ its 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 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 or facility 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 cover 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 after the health care service has been provided. It's a big problem for providers and facilities, and language to prevent this unfair practice by carriers needs to be included. Provider and facility representatives have talked about this at OIC stakeholder meetings, as well as provided written comments, but we had not provided language. Please see below, for some amendments to include this important missing piece concerning extenuating circumstances.)

(1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-

alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018. (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, and extenuating circumstance prevents the provider or facility from delivering the health care as described in the prior authorization. ~~For purposes of this section, an extenuating circumstance means a situation where a carrier must not deny a provider's claim for lack of prior authorization~~ 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) The provider is unable to anticipate that there is a need for a different medically necessary health care service that was not described in the prior authorization, during the delivery of outpatient or inpatient health care services. For example, a provider, in performing a surgery, determines that a different medically necessary health care procedure(s) must be used than originally anticipated in order to achieve the desired results, or a provider may request an imaging study, but the radiologist may decide, appropriately, that a different study, rather than the one initially ordered, should be performed.

(3) A carrier or ~~their~~ its designated or contracted representative may require providers and facilities to follow certain procedures in order for health care 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. (Deletes are those of the OIC, unless done in blue ink) The language in this section is not consistent in some instances,

with the language in the previous WACs. In this WAC, the term used is “issuer” not “carrier” for example. We started to make some changes, so that the language would be complementary to the other WACs, but too many changes are needed. Bottom line, this WAC needs a thorough review and discussion because as amended, it’s too confusing, in concert with the WACs on prior authorization.)

(1) These definitions apply to this section:

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

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

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

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

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

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

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

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

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

(2) Each issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a 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 "prospective review" is deleted below in subsection (f).

(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 facility at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider; (It is potentially confusing to have some portions of prior authorization in this WAC, and some in the others. Should this language be moved to the other main prior authorization WAC?)

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

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

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

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

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

(b) If the review request from the provider or facility is not accompanied by all necessary information, the issuer must tell the provider or facility what additional information is needed and the deadline for its submission. Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for issuer review determination and notification must be no less favorable than federal Department of Labor standards, as follows:

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

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

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