ANALYST CHECKLIST

**PROVIDER AND FACILITY AGREEMENTS**

Issuer:

Agreement Form Number:

GENERAL REVIEW REQUIREMENTS

Authority to Review Agreement – RCW 48.46.243, RCW 48.43.730, RCW 48.39.003, & WAC 284-170-480

DO **NOT** MAKE ANY CHANGES TO THIS CHECKLIST. IF THE CHECKLIST IS NOT APPLICABLE, OR IF THE PROVIDER OR FACILITY AGREEMENT DOES NOT COMPLY WITH ALL PROVISIONS OF LAW STATED BELOW, PLEASE EXPLAIN:

| **Administrative Policies** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.505  WAC 284-170-421(5) | The agreement must describe the responsibilities of providers and facilities under the issuer's administrative policies and programs, including but not limited to:   * 1. Payment terms;   2. Utilization review;   3. Quality assessment and improvement programs;   4. Credentialing;   5. Grievance, appeal, and adverse benefit determination procedures;   6. Data reporting requirements;   7. Pharmacy benefit substitution processes;   8. Confidentiality requirements; and   9. Any applicable federal or state requirements.   Generic statements and legal citations do not provide enough information. |  |

| **Appeals by Network Pharmacies to Pharmacy Benefit Managers (PBMs)** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 19.340.100  (effective 1/1/2022 recodified to RCW 48.200.280)  WAC 284-180-400 | A network pharmacy may appeal a reimbursement to a PBM if the reimbursement for the drug is less than the net amount the network pharmacy paid to the supplier of the drug. A PBM must include language in the pharmacy provider agreement and on its website fully describing the right to an appeal including:  (a) Contact information, including:  A telephone number by which the pharmacy may contact the PBM during normal business hours and speak with an individual responsible for processing appeals;  A summary of the specific times when the PBM will answer calls from network pharmacies at that telephone number;  A fax number that a network pharmacy can use to submit information regarding an appeal; and  An email address that a network pharmacy can use to submit information regarding an appeal;  (b) A detailed description of the actions that a network pharmacy must take to file an appeal; and  (c) A detailed summary of each step in the pharmacy benefit manager’s appeals process. |  |

| **Audit Guidelines** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-460 | 1. Provider and facility agreements may not grant the issuer access to health information unrelated to enrollees. 2. If the agreement grants the issuer access to medical records for audit purposes, the agreement must state that access is limited to information necessary to perform the audit. 3. The terms of any billing audit standards must be mutual: If the agreement allows the issuer to audit provider or facility billing records, then the provider or facility has the right to audit the issuer’s billing records. |  |

| **Chiropractor Services Payment Parity** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.190 | A health carrier may not pay a chiropractor less for a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code than it pays any other type of licensed provider for the same or substantially similar code, except that carriers may:   1. Implement a quality improvement program to promote cost effective and clinically efficacious health care services; 2. Contract with providers to comply with network adequacy standards; 3. Pay in-network providers differently than out-of-network providers; and 4. Pay a chiropractor less than another provider for procedures or services under the same or a substantially similar code based upon differences in the cost of maintaining a practice or carrying malpractice insurance, as recognized by a nationally accepted reimbursement methodology. |  |

| **Chiropractor Services Reimbursement** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.083 | 1. If a chiropractor signs the agreement, the issuer may not deny payment to the chiropractor if:    1. the service is covered chiropractic health care, provided by the chiropractor or the chiropractor’s employee; and    2. the chiropractor complies with the provider agreement. 2. If the issuer offers a chiropractor a participating provider agreement, the issuer must offer the same agreement to any other chiropractor within that practice providing services at the same location. |  |

| **Clean Claims** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-431 | Provider and facility agreements must describe the standards for the prompt payment of clean claims. Generic statements and bare legal citations do not provide enough information.   * 1. 95% of monthly clean claims must be paid within 30 days of receipt;   2. 95% of all claims must be paid or denied within 60 days;   3. 1% Interest per month must be paid on all non-denied and unpaid clean claims 61 days or older when issuer does not meet the standards; and   4. The definition of clean claim must be consistent with the WAC language. |  |
| *Pay and Pursue* |  |  |
| WAC 284-170-431  WAC 284-51-215 | Provider and facility agreements should explain how the issuer administers coordination of benefits:   1. Issuer must not unreasonably delay payment of a claim by reason of the application of COB. 2. Issuer must establish a time limit for payment of claims and may not unreasonably delay payment. |  |

| **Compensation Notification** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-421(6) | 1. Participating providers and facilities must be given reasonable notice of not less than 60 days of changes that affect provider or facility compensation or that affect health care service delivery. 2. Provisions for changing the terms of the agreement must permit the provider or facility to terminate the agreement rather than serve under unacceptable terms. However, the provider or facility must provide at least 60 days written notice to the issuer before termination. |  |

| **Conducting Business in Licensed Name** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.05.190  RCW 48.30.050  RCW 48.44.040  RCW 48.46.060 | Issuers conducting business in the State of Washington must do so under the name licensed. Provider and facility agreements filed with the OIC must clearly indicate the name of the issuer who is ultimately responsible for conditions identified in the agreement.   1. All parties to the agreement must be disclosed. 2. The names of the parties should be used consistently throughout the agreement.   The issuer cannot use one agreement to bind the provider or facility to all of the entities in the issuer’s corporate organization. The issuer must ask the provider or facility to sign a separate agreement with each affiliate. |  |

| **Content of Filing** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| *Complete Filing Documents* |  |  |
| RCW 48.46.243(3)(a)  RCW 48.43.730  WAC 284-170-480  WAC 284-44A-050  WAC 284-46A-050 | 1. All forms that are part of the agreement, including exhibits, payment schedules, regulatory appendix, etc., must be filed, in their entirety for review via SERFF. 2. Compensation exhibits and payment schedules must be filed separately in a “not-for public” filing as described in the Washington State SERFF Health and Disability Form Filing General Instructions. |  |
| *Examination/Disapproval* |  |  |
| WAC 284-170-480(1) | 1. Issuer must file for approval all provider and facility agreements at least 30 days prior to use. 2. Issuer must file for approval any negotiated agreement that deviates from an approved agreement at least 30 days prior to use. |  |
| *Template Filings and Negotiated Agreement Filings* |  |  |
| RCW 48.46.243(3)(a)  RCW 48.43.730  WAC 284-170-480(2) | An issuer may file a provider or facility agreement template with the OIC, which the issuer may use to contract with multiple providers or facilities. The template must be issued exactly as approved.  An issuer must submit changes to a template agreement to the OIC 30 days prior to use and include a redline.  Changes to a previously approved compensation exhibit modifying only the compensation amount or terms related to compensation must be filed and are deemed approved upon filing.  All negotiated agreements must be filed with the OIC 30 days prior to use and must include all contract documents. Once the OIC has a negotiated agreement on file, and the parties later negotiate only changes the compensation amount or terms related to compensation, then only the compensation exhibit must be filed and is deemed approved upon filing. |  |
| *Extension* |  |  |
| RCW 48.46.243(3)(b)  RCW 48.43.730  WAC 284-170-480(3) | If the commissioner takes no action within 30 days after submission, the form is deemed approved, **EXCEPT** the OIC may extend the approval period an additional 15 calendar days giving notice before the expiration of the initial 30 days. |  |
| *Issuer must maintain copies* |  |  |
| RCW 48.46.243  WAC 284-170-480(4) | The issuer must have access to all provider and facility agreements and provide copies to the OIC upon 20 days prior written notice from the commissioner. |  |
| *Selection Standards* |  |  |
| RCW 48.46.243  WAC 284-170-411(4) | An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner. |  |

| **Contracting Outside Health Care Plan** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.085 | 1. The agreement may not contain any provisions that will constrain enrollees, directly or indirectly, from freely contracting for services outside the plan on terms and conditions they choose. 2. The agreement must not discourage the provider or facility from contracting outside of the plan for non-covered services. |  |

| **Contract Termination** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-421(9) & (10) | 1. Issuer and participating providers and facilities must provide at least a 60-day notice to each other before terminating the agreement without cause. 2. Whether the termination was for cause, or without cause, the issuer must make a good faith effort to notify enrollees in writing at least 30 days prior to termination or immediately for a termination for cause that results in less than 30 day notice to a provider or carrier to all enrollees who are patients seen on a regular basis by a specialist; by a provider for whom they have a standing referral; or by a primary care provider.    1. The agreement does not need to contain the 30-day notice, but the agreement cannot contain conflicting language. |  |
| *Continuity of Care* |  |  |
| RCW 48.43.515(7) | An issuer must cover the services of a PCP whose agreement with the plan or whose agreement with a subcontractor is terminated without cause under the terms of that agreement for at least 60 days following notice of termination to the enrollee. |  |

| **Enrollee Coverage**  ***Non-discrimination*** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-421(11) | The agreement must instruct participating providers and facilities to furnish covered services to enrollees without regard to the enrollee's enrollment in the plan as a private purchaser or as a participant in the publicly financed programs of health care services. Providers and facilities should be notified, even if they do not participate in the publicly financed programs.  No wording should differentiate care for a subscriber who purchases privately vs. one on a public program. |  |

| **Enrollee Eligibility Notification** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.525  WAC 284-170-421(1) & (2)  WAC 284-43-3070(1)(b) | 1. The agreement must tell the provider or facility how to obtain eligibility and benefit information. 2. The agreement may not modify benefits, terms, or conditions contained in the health plan. In the event of a conflict between the agreement and the health plan, the benefits, terms, and conditions of the health plan must govern. 3. The agreement may not contain language for rescinding authorization and refusing payment even where treatment was pre-authorized. 4. The issuer must notify the provider of any adverse benefit determination that involves the pre-service denial of a treatment or procedure prescribed by the provider. |  |

| **Grievance Procedures** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.055WAC 284-170-421(13) WAC 284-170-440  *Kruger Clinic Orthopaedics v. Regence BlueShield*  *T 06-03* | 1. The agreement must describe the issuer’s procedures for review and adjudication of complaints arising out of the agreement. A reference to the issuer’s policy and procedure manual does not provide enough information. 2. Dispute resolution process:    1. Is there a formal process?    2. Not less than 30 days to file a dispute.    3. All likely disputes covered?    4. Unfairly advantages issuer?    5. Cannot exclude judicial remedies.    6. Cannot require binding Arbitration.    7. Billing disputes resolved within 60 days? 3. If the issuer fails to grant or reject a request for review within 30 days, the complaint can be considered “rejected” by the provider/facility and may be submitted to nonbinding mediation. |  |
| *Out of Network Payments:*  *Balance Billing – When Prohibited* |  |  |
| RCW 48.49.030  RCW 48.49.040 | 1. Carriers and out-of-network providers/facilities are required to negotiate in good faith to determine a commercially reasonable payment amount for services. Enrollees may not be held responsible for anything above their in-network cost share. 2. Carriers and out-of-network providers/facilities may pursue arbitration to determine a commercially reasonable payment amount as a dispute resolution process if good faith negotiations do not yield successful results. |  |

| **Hold Harmless & Insolvency** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-421(3) | Each provider and facility agreement must include the hold harmless and insolvency language as stated in the WAC. Providers and facilities must agree that:   * 1. They will not bill the patient for services provided under the contract;   2. They will continue treatment;   3. The contract cannot modify the enrollee’s rights under the health plan;   4. They will not bill the enrollee where issuer denies payment due to a breach of the agreement;   5. The hold harmless requirement survives the agreement; and   Subcontractors must also agree to the hold harmless requirement. |  |
| *Liability of Participant* |  |  |
| RCW 48.44.020(4)(a)  RCW 48.46.243(1) | Are all agreements in writing and state that in the event of issuer failure to pay for services the enrollee will not be liable to the provider or facility for sums owed by the issuer?  Does the agreement require that this hold harmless provision survives the termination of the agreement? |  |
| *Payment Collection* |  |  |
| RCW 48.80.030(5) & (6)WAC 284-170-421(4) | Agreements must inform providers/facilities that it is a class C felony to collect payment from enrollees in violation of the agreement. |  |

| **Indian Health Care Providers** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-310(5)(a) | Issuers are encouraged but not required to use the Indian Health Care Provider Addendum. If the issuer is using the addendum, is it the most current version of the:  “Washington State Indian Health Care Provider Addendum”?  <http://www.aihc-wa.com/>  “Model QHP Addendum for Indian Health Care Providers”?  <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/Model_QHP_Addendum_04_04_13.pdf> |  |
| *25 USC 1621(a)*  *Section 206(a) and (e)* | Does the addendum or agreement contain provision(s) that conflict with federal reimbursement requirements? |  |

| **Mental/Behavioral Health Providers** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.087(2)  RCW 48.43.087(3) | 1. No contracts between a mental health care practitioner (also known as a behavioral health provider) and an intermediary, or health carrier, may contain language preventing the practitioner and enrollee from agreeing to have services provided at the enrollees expense:  * when the enrollee’s mental health care coverage is exhausted, * during an appeal or adverse certification process, * when an enrollee’s condition is excluded from coverage, * or, for any other clinically appropriate reason at any time.  1. If a mental health practitioner provides services to an enrollee during an appeal or adverse certification process, the practitioner must provide written notification to the enrollee that payment for services is the enrollee’s responsibility, unless the carrier elects to pay. |  |

| **Military Service** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-390 | 1. Does the agreement contain any language that will deny a provider that leaves the network due to active duty military service, the right to return to the network after s/he returns to civilian status? 2. If the agreement contains such a provision, does the provision meet the timeframes set forth in the WAC? |  |

| **Network Name** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.730(7)  RCW 48.49.070  RCW 48.49.080  WAC 284-170-480(7) | 1. Does the provider agreement clearly state the carrier’s provider networks names in such a way that the provider or facility can understand their participation as an in-network provider and how the reimbursement is to be paid? 2. Does the provider agreement include a list, or other format acceptable to the commissioner, that allow a reasonable person to understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network? |  |

| **Non-covered Services**  ***Dental Services*** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.20.417  RCW 48.21.147  RCW 48.44.495 | Does the agreement contain language directly or indirectly prohibiting a participating dental provider from offering or providing a subscriber non-covered dental services on any terms or conditions acceptable to the dentist and the enrolled participant?  Does the agreement contain language directly or indirectly requiring a participating dentist to provide services to an enrolled participant for a fee set by, or subject to the approval of the carrier for non-covered services, including services that would be reimbursable under an enrollee’s coverage outside of contractual limitations such as benefit maximums, deductibles, coinsurance, waiting periods, or frequency limitations? |  |

| **Non-covered Services**  ***Health Care Services*** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.016(5) | Provider agreements may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party. |  |

| **Notice of Material Changes** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.39.003 et seq. | 1. Providers and facilities must be given at least a 60-day notice of changes that would require them to participate in a plan with a lower fee schedule in order to continue participation in a plan with a higher fee schedule. 2. Such notice must be given before the provider or facility’s notice period begins and must inform the provider or facility that they may reject the change without affecting the terms of their existing contract. |  |

| **Overpayment Recovery**  *Issuer Requirement* | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.600 | Provider agreements must explain the issuer’s procedures for overpayment recovery. Generic statements and legal citations do not provide enough information.   1. Except in the case of fraud, an issuer may not request a refund from a **health care provider** of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date payment was made. The time period must be reciprocal. 2. In the case of COB, the issuer must request a refund from a health care provider of payment previously made to satisfy a claim within 30 months after the date payment was made. 3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made. 4. Not applicable to subrogation claims. |  |
| *“HealthCare Provider” or “Provider” Requirement* |  |  |
| RCW 48.43.005(16)  RCW 48.43.605 | 1. Except in the case of fraud, a **health care provider** may not request payment from the issuer to satisfy a claim unless it does so in writing to the issuer within 24 months after the date the claim was denied or payment intended to satisfy the claim was made. 2. In the case of COB, the provider must request from the issuer within 30 months after original payment was made any additional balances owed. 3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made. 4. Not applicable to subrogation claims. |  |

| **Pharmacy Audit** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 19.340.040  (effective 1/1/2022 recodified to RCW 48.200.220) | An entity that audits pharmacy claims or contracts with another entity to audit such claims:   1. Must have a written appeals procedure and notify the pharmacy about the appeals procedure before conducting an audit; 2. May not audit a claim more than 24 months after adjudication; 3. Must notify the pharmacy 15 days before an on-site audit at the pharmacy or its corporate headquarters; 4. May not conduct an on-site audit during the first five days of any month without the pharmacy’s consent; 5. Must consult with a licensed pharmacist if the audit involves clinical or professional judgment; 6. May not conduct an on-site audit of more than 250 unique prescriptions within 12 months except in cases of alleged fraud; 7. May not conduct an on-site audit more than once every 12 months; 8. Must audit similar pharmacies under the same standards and parameters; 9. Must pay outstanding claims within 45 days after the earlier of the date all appeals are concluded or the date a final report is issued; 10. May not add dispensing fees or interest to any overpayment amounts unless the overpaid claim was for an incorrectly filled prescription; 11. May not recoup costs for clerical errors or other errors that did not result in financial harm to a consumer; and 12. May not charge a pharmacy for denied or disputed claims until the audit and appeals procedures are final. |  |
| RCW 19.340.050  (effective 1/1/2022 recodified to RCW 48.200.230) | An entity must find that a pharmacy claim was incorrectly presented or paid based on identified transactions and not based on probability sampling, extrapolation, or other projections. |  |

| **Pharmacy Emergency Fill Disclosure** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-470(7) | Every pharmacy provider or facility agreement must disclose that the issuer will authorize an emergency fill by the dispensing pharmacist and approve a claim for payment for the emergency fill when:   1. the dispensing pharmacy cannot reach the issuer’s prior authorization department by phone due the call being placed outside of the department’s business hours; or 2. the issuer is available by phone, but the issuer cannot reach the prescriber for full consultation.   The definition of “emergency fill” must be consistent with the WAC. |  |

| **Pharmacy Preauthorization Disclosure** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-470(5) | Every pharmacy provider or facility agreement must disclose:   1. whether the provider or pharmacy has the right to request preauthorization; and 2. that if the issuer requires the authorization number to appear on a pharmaceutical claim, the issuer will provide the number to the billing pharmacy after approval of the preauthorization request and upon receipt of a claim for that authorized medication. |  |

| **Prescription Drug Utilization** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.400  RCW 48.43.410  RCW 48.43.420(1)  RCW 48.43.420(2)  RCW 48.43.420(8)  RCW 48.43.420(9)  WAC 284-43-2020(2) | 1. Does the agreement include a statement advising providers the carrier has a readily accessible, and convenient process to request an exception to their drug utilization management process? **Note:** The agreement can direct the provider to the carrier’s website for further information. 2. Definitions described in 48.43.400 are specific to terms used in 48.43.410 and 48.43.420 3. Health carriers must disclose all rules and criteria related to their prescription drug utilization management process and include the specific information and documentation that must be submitted by a participating health care provider or patient to be considered a complete exception request. 4. The health carrier or prescription drug utilization management entity must permit a stabilized patient to remain on a drug during the exception request process. 5. A health carrier must provide 60 days’ notice to providers and patients for any new policies or procedures applicable to prescription drug utilization management protocols. New health carrier policies or procedures may not be applied retroactively. |  |

| **Prior Authorization** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.016(1)  RCW 48.43.016(2)  RCW 48.43.016(6)  RCW 48.43.016(7) | 1. If the agreement imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan, the carrier must inform the enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers. 2. The agreement cannot require utilization management or review of any kind for an initial evaluation and management visit, and up to six treatment visits with a contracting provider in a new episode of care for each of the following:    * Chiropractic    * Physical therapy    * Occupational therapy    * Acupuncture and Eastern medicine    * Massage therapy    * Speech and hearing therapies   Visits where utilization management or review is prohibited are still subject to quantitative treatment limits of the health plan. With the exception of RCW 48.43.515(5), the health plan can require a referral or prescription for the therapies listed.   1. For visits where utilization management or review is prohibited, a health carrier or its contracted entity may not:    * 1. Deny or limit coverage on the basis of medical necessity or appropriateness; or      2. Retroactively deny care or refuse payment for the visits. 2. A health carrier can deny coverage based on insurance fraud. |  |
| *Prior Authorization Process* |  |  |
| WAC 284-170-421(5)  WAC 284-43-2050 | 1. Does the contract require the issuer to give the provider 60 day notice before the issuer makes changes to its prior authorization program, including adding new prior authorization requirements to services or changing the clinical criteria used to approve prior authorization? 2. Does the contract include the method the issuer uses to accept prior authorization requests and the method for the provider to appeal a prior authorization denial? 3. Does the contract advise the provider that information relating to the prior authorization process can be found via a secure online process?   **NOTE: This provision does not apply to employees of a carrier with an integrated delivery system.** |  |

| **Protection of Individual Right to Privacy & Confidential Services** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.505 | 1. The health carrier may not require protected individuals to obtain permission from the policyholder, subscriber, or another covered person to receive care or submit a claim if they have the right to consent to care. 2. The health carrier must recognize the right of a protected individual or enrollee to exercise their rights regarding health information related to care they’ve received 3. The health carrier must direct all communications regarding a protected individual’s receipt of sensitive health services to the patient receiving care, or via postal mail, e-mail, or telephone number specified by the protected individual. Carriers may not disclose information to anyone other than the protected individual without their written, or recorded verbal consent. 4. A protected individual may request communications regarding the receipt of sensitive health care services be sent to another individual or provider for the purposes of appealing adverse benefit determinations. 5. The health carrier will limit disclosure of any information about a protected individual who is the subject of the information and will direct communications directly to the protected individual, or via mail, e-mail, or phone number specified by the protected individual upon request. 6. The health carrier may not require a protected individual to waive any right to limit disclosure as a condition of eligibility or coverage. 7. To protect patient confidentiality, any communication from a carrier relating to care – if the communications disclose protected health information, information relating to sensitive services – must be provided in the form & format requested by the patient receiving care. |  |

| **Provider Credentialing Application** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| *Electronic Database Use - Carrier* |  |  |
| RCW 48.43.750 | * The agreement may not require the carrier to submit credentialing information in any format other than through the state-approved database per RCW 48.165.035 * The agreement may not specify a credentialing determination period longer than 90 days after receiving a complete application from the provider |  |
| *Electronic Database Use - Provider* |  |  |
| RCW 48.43.755 | * A carrier may require a provider to submit credentialing information using the state-approved database per RCW 48.165.035 * A carrier may require a provider to update credentialing information as necessary for the purposes of recredentialing. |  |
| RCW 48.43.750(2)  RCW 48.43.755(3) | *The database use requirements listed above* ***do not*** *apply to entities that utilize credentialing delegation arrangements for credentialing health care providers with carriers.* |  |
| *Reimbursement Requirements* |  |  |
| RCW 48.43.757 | * The agreement must allow for the payment of covered services by the health plan to a provider in a new contract, starting with the contract effective date, regardless of the credentialing process being incomplete * The agreement must allow for the payment of covered services provided to enrollees by the health plan for health care providers joining a provider organization with an existing contract between the carrier and provider organization. Payment is allowed starting from the date the completed credentialing application was submitted to the carrier. * The agreement must allow reimbursement to be at the contracted rate, as if the credentialing process were already complete. * The carrier is not required to pay for provider-rendered services that are not covered benefits or services under the enrollee’s benefit plan. * A carrier is not required to reimburse for covered services rendered by a provider if the provider’s credentialing application is not approved, or if the carrier and provider do not enter into a contractual relationship. |  |

| **Provider/Patient Care** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.510(6)  RCW 48.43.510(7)  WAC 284-170-421(7)(a) & (b) | Each provider and facility agreement must include the language from the WAC allowing providers to inform patients about care and issuer merits. |  |

| **Provider Manual**  **(Should Not Be Incorporated in Agreement)** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.055  RCW 48.46.243  WAC 284-170-411(4)  WAC 284-170-421  WAC 284-170-480(4) | 1. The entire provider or facility agreement must be filed for review. 2. Analyst should consider if terms & conditions referenced to the provider manual should be incorporated into provider agreement. 3. If the provider or facility agreement references or incorporates by reference additional documents, administrative manuals, or procedures, such documents, manuals, and procedures must be submitted to the OIC for approval. |  |

| **QHP Participation** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| RCW 48.43.775 | The agreement cannot require a provider or facility participating in a Qualifying Health Plan to accept the QHP reimbursement rates for all of the carrier’s other plans. |  |

| **Record Retention** | **Specific Issues** | **Location (Page/Section #) or comments** |
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| WAC 284-170-421(8) | Issuer must require providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees subject to applicable state and federal laws related to confidentiality of medical or health records. |  |

| **Signature Block** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| Federal E-Sign Act | Acceptable formats include:   * The electronically signed contract signature page attached to the provider agreement * If a copy of the electronic signature page cannot be produced, a statement must be placed in the General Information tab of the SERFF filing advising the agreement was electronically signed and done so in a manner that complies with the Federal E-Sign Act. |  |

| **Standard of Care** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| RCW 48.43.545 | 1. Issuer may not unfairly transfer liability. 2. Are Indemnity/liability clauses consistent with the responsibility/right to determine when treatment is medically necessary? |  |

| **Subcontractors** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| WAC 284-170-240  WAC 284-170-401 | 1. Has the issuer filed 1) an executed copy of its agreement with a subcontracted network and 2) copies of the subcontracted network’s agreements with its providers and facilities, following the procedures set out in the Washington State SERFF Health and Disability Form Filing General Instructions? 2. A subcontracted network must include all providers in the network that have a signed and executed agreement for that network. The agreement may not contain any language that would allow: 3. for providers to be excluded from participation; or 4. for the issuer to select providers for inclusion in a subcontracted network.   An issuer must ensure that subcontracted providers and facilities meet all of the requirements that apply to contracted providers and facilities. |  |

| **Telemedicine Payment Parity** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| RCW 48.43.735 | 1. The agreement must compensate providers for telemedicine services at the same rate\* as in-person services. 2. The carrier can negotiate a telemedicine reimbursement rate that differs from in-person services for:    * hospitals,    * hospital systems,    * telemedicine companies, and    * provider groups consisting of 11 or more providers. 3. The carrier can negotiate payment of facility fees for telemedicine services that originate at:  * a hospital, * a rural health clinic, * a Federally qualified health center, * a physician/health care provider’s office, * community mental health center, skilled nursing facility, or * a renal dialysis center (except an internal renal dialysis center).  1. Any other sites **may not** charge a facility fee. 2. The carrier may not distinguish between originating sites that are rural and urban when providing coverage. 3. The carrier is not required to reimburse:  * an originating site for professional fees, * services not covered under the plan, or * an originating site or provider that is not contracted under the plan.   \*The term “rate” needs to be defined by the Legislature |  |

| **Temporary Substitution of Contracted Providers**  **“Locum tenens”** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| WAC 284-170-380 | The agreement may not restrict a contracted provider from arranging for a substitute provider for at least 60 days during any calendar year. The issuer must grant an extension if the contracted provider demonstrates that exceptional circumstances require additional time away from his or her practice. |  |

| **Tiered Networks** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| WAC 284-170-330 | 1. Does the agreement clearly identify to the provider or facility that the issuer agreement is for a tiered network? 2. Does the agreement include language identifying for the provider or facility that if the issuer revises or amends a quality, cost efficiency or tiering program related to its network that it will provide at least a 60-day notice of this change? 3. Has the issuer guaranteed in the agreement that it will provide the physician/facility cost profile, including written criteria by which the provider’s or facility’s performance is measured? 4. If the agreement includes information about notification requirements; has the issuer properly required the notice to be sent from the issuer? The responsibility for notification cannot be transferred to the provider/facility. |  |

| **Utilization Review** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| RCW 48.43.520  RCW 48.43.525  WAC 284-43-2000 | 1. The agreement must tell the provider or facility how to obtain preauthorization. 2. Issuer may not retrospectively deny coverage for emergency or non-emergency care that was preauthorized. 3. Retrospective review decisions are based solely on the medical information available to the attending physician at time the health services were provided. 4. Retrospective review determinations must be completed within 30 days of receipt of the necessary information. |  |

| **Withdrawal Management Services** | **Specific Issues** | **Location (Page/Section #) or comments** |
| --- | --- | --- |
| RCW 48.43.761  WAC 284-43-2000 | 1. The contract cannot specify timeframes for substance abuse disorder treatment less than what is specified in RCW 48.43.761(2)(a)(i) 2. The contract cannot specify timeframes for withdrawal management services less than what is specified in RCW 48.43.761(2)(a)(ii) 3. The contract cannot contain language that prevents a seamless transfer to an appropriate level of care. |  |