RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (October 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

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STATE OF WASHINGTON
FILED

DATE: December 27, 2024
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WSR 25-02-084

Agency: Office of the Insurance Commissioner — Insurance Commissioner Matter R 2024-03

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: In 2023, the Legislature modernized prior authorization processes to prevent delays in care and improve health outcomes. To implement those objectives, the OIC resumed its proposed rulemaking on prior authorization revisions from last year's E2SHB 1357 (RCW 48.43.830). Multiple Washington Administrative Code provisions within Chapter 284-43 needed amendments to update prior authorization processes and timelines and to be consistent with the enacted legislation.

This rulemaking facilitates implementation of these laws by ensuring that all affected health care entities understand their rights and obligations.

Citation of rules affected by this order:

New:
Repealed:
Amended: WAC 284-43-2020; WAC 284-43-2050
Suspended:

Statutory authority for adoption: RCW 48.02.060, RCW 48.43.0161, and RCW 48.43.520.

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 24-22-130 on November 5, 2024 (date).

Describe any changes other than editing from proposed to adopted version: There are no changes from the proposed rule to the adopted rule.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Simon Casson
Address: PO Box 40255, Olympia, WA 98504-0255
Phone: 360-725-7038
Fax: 360-586-3109
TTY:
Email: rulescoordinator@oic.wa.gov
Web site: www.insurance.wa.gov
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended	2	Repealed	

The number of sections adopted at the request of a nongovernmental entity:

	New		Amended		Repealed	

The number of sections adopted on the agency's own initiative:

	New		Amended		Repealed	

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New		Amended	2	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New		Amended		Repealed	

Date Adopted: December 27, 2024

Name: Mike Kreidler

Title: Insurance Commissioner

Signature:

AMENDATORY SECTION (Amending WSR 20-24-105, filed 12/1/20, effective 1/1/21)

WAC 284-43-2020 Drug utilization review—Generally. (1) These definitions apply to ((~~this section only~~)) the prescription drug utilization management timelines covered in this section only, excluding prescription drug prior authorization timelines, which are covered in WAC 284-43-2050:

(a) "Nonurgent 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~~)), or a renewal of a previously approved request((~~, and~~)) that is not an urgent care request.

(b) "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 provider 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 drug utilization review program that meets the definitions and requirements of RCW 48.43.400 and 48.43.410. "Utilization review" has the same meaning as defined in RCW 48.43.005. The program must include a method for reviewing and updating criteria. Issuers must make drug review criteria available upon request to a participating provider. Beginning January 1, 2021, an issuer must post its clinical review criteria for prescription drugs and the drug utilization management exception process on its website. An issuer must also require any entity performing prescription drug benefit administration on the issuer's behalf to post the drug utilization management exception process and clinical review criteria used for the issuer's enrollees on the entity's website. The review criteria must be accessible to both providers and enrollees and presented in plain language that is understandable to both providers and enrollees. The clinical review criteria must include all rules and criteria related to the prescription drug utilization management exception process including the specific information and documentation that must be submitted by a health care provider or enrollee to be considered a complete exception request.

(3) The drug 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.

(4) The drug utilization review program must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(5) Each issuer must have written procedures to assure that reviews are conducted in a timely manner.

(a) If the review request from a provider or enrollee is not accompanied by all necessary information, the issuer must tell the provider or enrollee 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 determination and notification must be no less favorable than United States Department of Labor standards, and are as follows:

(i) For urgent care review requests:

(A) Must approve the request within ((~~forty-eight~~)) 48 hours if the information provided is sufficient to approve the claim ((~~and include the authorization number, if a prior authorization number is required, in its approval~~));

(B) Must deny the request within ((~~forty-eight~~)) 48 hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or

(C) Within ((~~twenty-four~~)) 24 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~~)) utilization management determination:

(I) The issuer must give the provider ((~~forty-eight~~)) 48 hours to submit the requested information;

(II) The issuer must then approve or deny the request within ((~~forty-eight~~)) 48 hours of the receipt of the requested additional information and include the authorization number in its approval;

(ii) For nonurgent care review requests:

(A) Must approve the request within five calendar days if the information is sufficient to approve the claim and include the authorization number in its approval;

(B) 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~~)) utilization management 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 and include the authorization number in its approval.

(b) Notification of the ((~~prior authorization~~)) utilization management determination must be provided as follows:

(i) Information about whether a request was approved must be made available to the provider;

(ii) Whenever there is an adverse determination resulting in a denial the issuer must notify the requesting provider by one or more of the following methods; phone, fax and/or secure electronic notification, and the covered person in writing or via secure electronic notification. Status information will be communicated to the billing pharmacy, via electronic transaction, upon the issuer's receipt of a claim after the request has been denied. The issuer must transmit these notifications within the time frames specified in (a)(i) and (ii) of this subsection in compliance with United States Department of Labor standards.

(6) When a provider or enrollee requests an exception to an issuer's drug utilization program, the urgent and nonurgent time frames established in RCW 48.43.420, WAC 284-43-2021 and 284-43-2022 shall apply.

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

AMENDATORY SECTION (Amending WSR 20-24-120, filed 12/2/20, effective 1/2/21)

WAC 284-43-2050 Prior authorization processes. (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. Unless stated otherwise, this section does not apply to prescription drug services. For health plans as defined in RCW 48.43.005, carriers must meet the requirements of RCW 48.43.830 in addition to the requirements in this section.

(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria. A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria and use the medical necessity definition stated in the enrollee's plan. The prior authorization program must include a method for reviewing and updating clinical review criteria. A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program. A carrier or its designated or contracted representative is not required to use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

(3) A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of this chapter. A 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) Effective November 1, 2019, a carrier or its designated or contracted representative must have a current and accurate online prior authorization process. All parts of the process that utilize personally identifiable information must be accessed through a secure online process. The online process must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system. The online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) What, 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) Effective November 1, 2019, in addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for services must have a secure online process for a participating provider or facility to complete a prior authorization request and upload documentation if necessary. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system.

(6) Except for an integrated delivery system, a carrier or its designated or contracted representative must have a method that allows an out-of-network provider or facility to:

(a) Have access to any preservice requirements; and

(b) Request a prior authorization if prior authorization is required for an out-of-network provider or facility.

(7) A carrier or its designated or contracted representative that requires prior authorization for any service must allow a provider or facility to submit a request for a prior authorization at all times, including outside normal business hours.

(8) A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted.

(a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted by a provider or facility during the processing of a prior authorization request.

(b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information communicated by the provider or facility.

(9) A carrier or its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations for a participating provider or facility are made within the appropriate time frames.

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

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

(10) For health plans as defined in RCW 48.43.005, the prior authorization time frames for health care services and prescription drugs in RCW 48.43.830 apply.

(a) For purposes of the prior authorization time frames in RCW 48.43.830 and this subsection, the following definitions apply:

(i) "Electronic prior authorization request" means a prior authorization request that is delivered through a two-way communication system that meets the requirements of a secure online prior authorization process or an interoperable electronic process or prior authorization application programming interface.

(ii) "Nonelectronic prior authorization request" means a prior authorization request other than an electronic prior authorization re-

quest including, but not limited to, requests delivered through email, a phone call, a text message, a fax, or U.S. mail.

(b) If insufficient information has been provided to the carrier to make a prior authorization determination and the carrier requests additional information from the provider or facility under RCW 48.43.830, the initial prior authorization request time frames in RCW 48.43.830 apply once the carrier has the necessary information to make a determination. Those time frames are as follows:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of receiving the necessary information needed to make the determination.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of receiving the necessary information needed to make the determination.

(iii) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of receiving the necessary information needed to make the determination.

(iv) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of receiving the necessary information needed to make the determination.

(11) For limited health care services contracts as defined in RCW 48.44.035, stand-alone dental plans, and stand-alone vision plans, the time frames for carrier prior authorization determination and notification to a participating provider or facility are as follows:

(a) For standard prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within five calendar days.

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

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

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

(b) For expedited prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within two calendar days.

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

(A) The carrier or its designated or contracted representative must give a provider or facility two calendar days to give the neces-

sary information to the carrier or its designated or contracted representative.

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

(iii) If the time frames for the approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.

((~~(11)~~)) (12) A carrier or 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 authorization process;

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

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

(d) 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.

((~~(12)~~)) (13) When a provider or facility makes a request for the prior authorization, the response from the carrier or its designated or contracted representative must state if it is approved or denied. If the request is denied, the response must give the specific reason for the denial in clear and simple language. If the reason for the denial is based on clinical review criteria, the criteria must be provided. Written notice of the decision must be communicated to the provider or facility, and the enrollee. A decision may be provided orally, but subsequent written notice must also be provided. 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.

Whenever the prior authorization relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

((~~(13)~~)) (14) A prior authorization approval notification for all services must inform the requesting provider or facility, and the enrollee, 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 so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.

Whenever the notification relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

((~~(14)~~)) (15) A provider or facility may appeal a prior authorization denial to the carrier or its designated or contracted representative.

((~~(15)~~)) (16) Prior authorization determinations shall expire no sooner than ((~~forty-five~~)) 45 days from date of approval. This requirement does not supersede RCW 48.43.039.

((~~(16)~~)) (17) In limited circumstances when an enrollee has 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), the subsequent carrier or its designated or contracted representative must recognize the prior authorization of the previous carrier until the new carrier's prior authorization process has been completed and its authorized treatment plan has been initiated. The subsequent carrier or its designated or contracted representative must ensure that the enrollee receives the previously authorized initial service as an in-network service. Enrollees must present proof of the prior authorization.

(a) For medical services, a carrier or its designated or contracted representative must recognize a prior authorization for at least ((~~thirty~~)) 30 days or the expiration date of the original prior authorization, whichever is shorter.

(b) For pharmacy services, a carrier or its designated or contracted representative must recognize a prior authorization for the initial fill, or until the prior authorization process of the new carrier or its designated or contracted representative has been completed.

((~~(17)~~)) (18) 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 its designated or contracted representative at the time of the prior authorization request.

((~~(18)~~)) (19) A carrier or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee.

((~~(19)~~)) (20) A carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to make a predetermination request when provided for by the plan.

((~~(20)~~)) (21) Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered." Predetermination notices must be delivered within five calendar days of receipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) If any preservice requirements apply;

(d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information:

(i) The clinical review criteria used to evaluate the request; and

(ii) Any required documentation.

(e) Whenever a predetermination notice relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.