Rules coordinator (policy) - Secure

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Comment(s) or question(s)	I realize commenting is closed on this matter but I'm going to comment anyway.... 1) I've read a lot of RCWs and WACs (I trained to be a paralegal) and have worked in the medical field for 18 years, I have trouble understanding about 75% of this WAC. The one part I do understand scares the heehee out of me. The part that says: "refusal to pay for higher cost drugs until it can be shown that a lower cost drug or medication is not effective (also known as step therapy protocols or fail-first policies), establishing a preferred brand and nonpreferred brand formulary, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process as set forth in subsection" is a scary, scary proposition. Insurance companies tend to be very liberal with their views as to medical standards of care and often, particularly with prescriptions are in direct conflict with them but, short of taking them to court, there is nothing that can be done. If you give them leeway on this, it is going to be impossible. (Insurance companies are masters at pulling pieces of clinical information or guidelines and stating them in their policies while ignoring the real meaning of what they are quoting because it doesn't fit with what they want). For example, years ago I was placed on Provigil for narcolepsy. They didn't want to pay for it, stating that I had to take ritalin or adderall because way back in the 60s or 70s that was all they had to treat narcolepsy and there was (is) a RCW stating that those drugs can't be denied for the use of narcolepsy. Never mind the fact that Pulmonary Association (I can't remember which one because it was a long time ago) stated that ritalin and adderall should be used as last resort to treat narcolepsy and my pulmonologist refused to use medications that his clinical guidelines stated should be used as last resort. (I researched the matter myself and wrote my own appeal so I know that the provider wasn't being unreasonable.) All I can say is be extremely careful how you word it and be very specific with what is allow or not because then we can at least address the matter with the insurance commissioner, otherwise there is going to be a lot of headaches you can't for see. Again, I realize that the commenting is closed but what you should really do is send out a survey to providers (maybe through the Washington State Medical Association's mailing list) explaining the law in English and what this means and get their take on the matter. Since you don't have a working knowledge of life on the front lines, directly asking people who would have to deal with how it would impact the working of the offices. One final point, while I see the purpose of step therapy, in theory, the amount of prior authorizations and step therapy authorizations have already grown exponentially. Just last year I did about 4-5 authorizations in a week (small office) now I do about 4-5 in a day. Since providers are supposed to only count face time as to the complexity of a patient, there needs to be some nominal reimbursement for all these prior auths and step edits. I know what is require, I rarely get them denied (unless they are newer or have

	changed, sometimes I get a curve ball). All this extra time consuming work when you are already doing things correctly. And they do take time. I just do one for Moda health (Uniform Medical) and I very nicely went through his medication history and listed all his lipid medications and outcomes on letterhead because he had been our patient for 20 years. They came back and said they wanted chart notes. I said, "You want to 20 years worth of chart notes?" "No, just send relevant ones..." "So you want me to go through 20 years worth of chart notes...." I think that PA took me thirty minutes to get an approval for a medication he has been on 5-10 years. (It was a new plan to him). I know offices where EMR are fully implemented already struggle with prior authorizations.
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Start Time	2016-10-28 15:07:25
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