OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Health Plan Prior-Authorization Data

2020 Report

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www.insurance.wa.gov

Table of contents

Background

In 2020, the Washington State Legislature enacted Engrossed Substitute Senate Bill (ESSB) 6404 (Chapter 316, Laws of 2020, codified at RCW 48.43.0161), which requires that carriers with at least one percent of the market share in Washington State annually report certain aggregated and de-identified data to the Office of the Insurance Commissioner (OIC). This reported data includes prior-authorization information for the following codes:

- Inpatient medical/surgical codes
- Outpatient medical/surgical codes
- Inpatient mental health and substance use disorder codes
- Outpatient mental health and substance use disorder codes
- Diabetes supplies and equipment codes
- Durable medical equipment codes

The carriers must report the following information for the prior plan year (PY) for their individual and group health plans for the codes listed above:

- The ten highest total number of prior-authorization requests, including the total number of requests and percent of approved requests for each code.
- The ten highest percentage of approved prior-authorization requests, including the total number of requests and percent of approved requests for each code.
- The ten highest percentage of prior-authorization requests that were initially denied and then approved on appeal, including the total number of requests and the percent of requests initially denied and then subsequently approved for each code.

Reporting carriers must also include the average response time in hours for prior-authorization requests with respect to each covered service in the above lists for each of the following categories:

- Expedited decisions.
- Standard decisions.
- Extenuating-circumstances decisions.

The first report from carriers was due to the OIC on October 1, 2020, for PY 2019. Per the statute, reporting will continue to occur annually.

The Revised Code of Washington (RCW) 48.43.0161(3) directs the insurance commissioner to aggregate and de-identify the data collected above into an annual report by January 1, 2021, and yearly thereafter. The report may not identify the name of the carrier that submitted the data.

OIC Implementation of ESSB 6404

The Office of the Insurance Commissioner (OIC took the following steps in 2020 to establish reporting under RCW 48.43.0160:

- **May 6:** Distributed drafts of the filing instruction sheet, response template, and hardship exemption request to carriers and provider stakeholders.
- **May 14:** Hosted a 90-minute webinar for carriers and provider stakeholders. During the webinar, the OIC reviewed its proposed implementation timeline and draft materials. Stakeholders were asked to submit written comments and questions by May 21. Comments received were taken into consideration during development of a subsequent draft; questions were addressed as part of the revision process.
- **June 4**: Distributed a final draft of the filing instruction sheet, response template, and hardship exemption request process to stakeholders, and provided an additional opportunity to submit comments by June 11. Comments received were taken into consideration during preparation of the final reporting template, instructions and hardship exemption process.
- **June 18:** Notified the carriers required to file a report in 2020 for PY 2019 based upon market share as directed in RCW 48.43.0160(1). Carriers notified included:
    - Premera Blue Cross
    - LifeWise Health Plan of Washington
    - Regence BlueShield
    - Regence BlueCross BlueShield (BCBS) of Oregon
    - Asuris Northwest Health
    - Kaiser Foundation Health Plan of Washington
    - Kaiser Foundation Health Plan of Washington Options
    - Kaiser Foundation Health Plan of the Northwest
    - Aetna Life Insurance Company
    - Coordinated Care Corporation
    - Molina HealthCare of Washington
    - UnitedHealthCare Insurance Company
    - UnitedHealthCare of Washington Incorporated

  The OIC also distributed to carriers the final ESSB 6404 Instruction Sheet (Appendix A), ESSB 6404 Response Template (Appendix B), and ESSB 6404 Hardship Exemption request process (Appendix C). To keep responses consistent and make them easier to compare, the OIC directed the carriers to report data based on the date a service was provided. In addition, carriers were to include a service description along with the applicable code (e.g. Current Procedural

Terminology (CPT), Healthcare Common Procedure Coding (HCPC)). Carriers were provided an opportunity to submit additional questions.

- **July 15**: Hardship exemption requests were due to the OIC. No hardship exemptions were requested for PY 2019 data.
- **September 1 – October 1**: Carriers reported to the OIC.

Carrier Reporting

In 2015, the OIC adopted rules that established minimum program and process standards for carriers' prior-authorization activities. The rules, codified in Washington Administrative Code (WAC) 284-43-2000 through 284-43-2060, include but are not limited to:

- Prior-authorization program accreditation, e.g. accreditation by the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Joint Commission, or Accreditation Association for Ambulatory Health Care (AAAHC).
- Use of evidence-based clinical review criteria.
- Establishment of an online prior-authorization submission process to provide more transparency and clearer guidance for providers and enrollees.
- Establishment of a secure online process for providers to submit prior-authorization requests.
- Setting time limits for making prior-authorization decisions.
- Required content of prior-authorization approvals and denials.

RCW 48.43.0161 addresses the clinical services that are subject to prior-authorization, rather than the processes used by carriers to conduct prior-authorizations.

- Carriers submitted their PY 2019 reports in a timely manner.
- Reporting varied substantially among carriers. A small number of responses did not include all of the requested information related the services reported (e.g., missing service descriptors).
- Many of the reports did not include complete responses related to average determination response time for expedited prior-authorization decisions.

Across the carriers, there was substantial variability in both the particular services or codes that were reported and the number of claims reported for each such service.

To provide some context, as of January 1, 2020, there were over 11,000 Common Procedure Terminology (CPT) codes and 6,700 Healthcare Common Procedural Coding System (HCPCS) codes in use.[1] While the Legislature has limited prior-authorization for certain services (e.g., initial substance use disorder inpatient stays (RCW 48.43.761), medication for treatment of opioid use disorder (RCW 48.43.760), chiropractic, physical therapy, and East Asian treatments (RCW 48.43.016), the OIC is not aware of standardization of services that are subject to prior-authorization. A single type of health care service may be billable with multiple revenue or service codes. PY 2019 reporting suggests that carriers do not require similar coding when authorizing services. Coding expertise would be needed to

[1] CPT codes are developed by the American Medical Association, https://www.ama-assn.org/amaone/cpt-current-procedural-terminology; HCPCS codes are developed by the HHS/Center for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo.

appropriately group these services to discern a trend in carriers' prior-authorization practices. The OIC does not have such expertise in-house.

Conclusion

While the OIC understands the statutory direction to aggregate the data, the inconsistencies in reporting means the OIC cannot reasonably do so. For that reason, this report provides each carrier's response consistent with legislative direction to de-identify the submitted data.

In 2021, the OIC will work with carriers, the Washington State Medical Association (WSMA), the Washington State Hospital Association (WSHA), and other interested parties to identify refinements to the reporting instructions and template with a goal of receiving accurate and complete reports in future years. For example, the OIC will likely add an indicator showing whether a code listed is a CPT code, a HCPCS code, or a revenue code. Having a baseline of first-year reports should assist in development of reporting modifications to meet the Legislature's intent. However, if the variability in codes reported remains so in future years, aggregating the reported data may once again be impractical.

Appendix A

ESSB 6404 Data Reporting Instruction Sheet (Instructions as sent to carriers)

For 2020 Data Submission (based on PY 2019 data)

Responses should be submitted to OIC at: market.conduct@oic.wa.gov

June 18, 2020

Sec. 1(1) of ESSB 6404 identifies the carriers required to report prior-authorization data based upon a threshold percentage of premiums written in Washington State. In interpreting this language, OIC took into consideration the codification of ESSB 6404 in chapter 48.43 RCW, which relates to regulation of health plans, and consistency with existing National Association of Insurance Commissioner (NAIC) carrier financial reporting requirements. OIC has calculated the 1% threshold based upon premiums written in the individual, student health plan, small group and large group markets during 2019 as reported to NAIC in the Supplemental Health Care Exhibit. The following carriers meet the 1% threshold for calendar year (CY) 2019:

- Premera Blue Cross
- LifeWise Health Plan of Washington
- Regence BlueShield
- Regence BlueCross BlueShield (BCBS) of Oregon
- Asuris Northwest Health
- Kaiser Foundation Health Plan of Washington
- Kaiser Foundation Health Plan of Washington Options
- Kaiser Foundation Health Plan of the Northwest
- Aetna Life Insurance Company
- Coordinated Care Corporation
- Molina HealthCare of Washington
- UnitedHealthCare Insurance Company
- UnitedHealthCare of Washington Incorporated

By October 1, 2020, for Washington State residents enrolled in commercial health plans issued in Washington State, the carriers listed above must report the de-identified and aggregated data listed below to the Insurance Commissioner for CY 2019 using the Excel workbook accompanying these instructions.

To ensure that the October 1, 2020, reporting deadline is met, **carriers are strongly encouraged to submit their data by September 1, 2020**. This will provide OIC the opportunity to review each carrier's initial submission and ensure that it is in compliance with the requirements of the law prior to the October 1 statutory deadline.

The data to be reported is as follows:

- The ten inpatient medical or surgical codes, ten outpatient medical or surgical codes, ten inpatient mental health and substance use disorder codes, ten outpatient mental health and substance use disorder codes**,** ten diabetes supplies and equipment codes, and ten durable medical equipment codes with:
    - The highest total number of prior-authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code;
    - The highest percentage of approved prior-authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code. If more than ten codes have an approval rate of 100%, the carrier should default to those codes with the greatest number of prior-authorization requests;
    - The highest percentage of prior-authorization requests that were initially denied, appealed by an enrollee and then subsequently approved on appeal, counting internal and external appeals, including the total number of requests and the percent of requests initially denied and then subsequently approved for each code; and
- The average determination response time in hours for prior-authorization requests to the plan with respect to each covered service included in the lists above for each of the following categories:
    - expedited decisions;
    - standard decisions; and
    - Extenuating circumstances decisions. OIC assumes that per WAC 284-43-2060, prior-authorization will not have occurred for these claims. Under WAC 284-43-2060(6), claims and appeals related to an extenuating circumstance may still be reviewed for appropriateness, level of care, effectiveness, benefit coverage and medical necessity under the criteria for the applicable plan, based on the information available to the provider or facility at the time of treatment. For claims processed via extenuating circumstances, the carrier should report the average response time in which authorization occurred following notification to the carrier by the provider or claim submission. In its reporting, a carrier may distinguish between claims for which a provider has notified the carrier of an extenuating circumstance prior to claims submission, and those claims that are administratively denied because a provider did not report the extenuating circumstances prior to claim submission and are then disputed by the provider.

      ESSB 6404 requires reporting of response time in hours. A carrier whose data system does not track time in hours, but rather days, may use 8 hours if the approval occurs within one day, but should report a day as 24 hours if there are multiple days involved.

Attached is an Excel workbook for the carrier to enter its data. Each service category has a tab with a labelled worksheet that contains three (3) tables. The tables correspond with the requirements above. The top ten (10) codes entered into each **table are to be unique to each question asked in Column B**. For each code or codes (if the same service can be billed using more than one type of code) reported, provide a description of the service to which the code applies. Please report data for calendar year 2019, based upon the date of service.

Definitions:

- Codes - For purposes of this report, codes include CPT, HCPC and revenue codes. If the same service can be paid using more than one type of code, e.g. both a HCPC and a revenue code, then prior-authorization requests using either code should be combined in calculating the number of prior-authorization requests. However, if a CPT or HCPC code applies to both medical/surgical and mental health/substance use disorder diagnoses, the volume of prior-authorization requests for the service should be calculated separately for medical/surgical diagnoses and for mental health/substance use disorder diagnoses to determine whether that code constitutes one of the top ten codes for either medical/surgical or mental health/substance use disorder services. "Unlisted codes", which are used when there is not CPT or HCPC code that accurately identifies the surgery or procedure being performed, should not be considered "codes" for purposes of reporting.
- Diabetes Supplies & Equipment – Materials and equipment used to assist in the monitoring of diabetes, including but not limited to blood sugar (glucose) test strips, blood glucose monitors, lancet devices, lancets, and glucose control solutions for checking the accuracy of test strips and monitors.
- Durable Medical Equipment - Durable medical equipment is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. As defined in RCW 48.43.290, the HealthCare.gov glossary and for Medicare coverage, durable medical equipment does not include implantable devices, prosthetics or orthotics.
- Expedited Request Decisions - any request by a provider or facility for approval of a 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 or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request (See WAC 284-43-0160 and WAC 284-43-2050).
- Extenuating Circumstance - an extenuating circumstance means an unforeseen event or set of circumstances, which adversely affects the ability of a participating provider or facility to request prior-authorization prior to service delivery (See WAC 284-43-2060).
- Prior-Authorization – A mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. This includes

any term used by a carrier or its designated or contracted representative to describe this process. Per the definitions of "prior-authorization" and "authorization" in WAC 284-43-0160, prior-authorization occurs before a service is delivered and does not include continued stay reviews.

- Standard Request Decisions - a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited (See WAC 284-43-0160 and 284-43-2050).

For questions, please contact Ned Gaines at (360) 725-7216 or submit an e-mail to market.conduct@oic.wa.gov.

Appendix B

ESSB 6404 Hardship Exemption Process (Instructions as sent to carriers)

For Reporting Due October 1, 2020

June 17, 2020

A **hardship exemption** is an event that prevents a carrier from timely submitting a response to the data call for section 1, subsections (1)(a)(iii), (b)(iii),11(c)(iii), (d)(iii), (e)(iii), or (f)(iii) of ESSB 6404. There is no extension available for the data required under all other subsections. A hardship exception must be due to **unanticipated** technical difficulties that prevent the timely preparation and submission of the data call information by the required due date. Any difficulties that could have been assessed and corrected prior to submission will not be unanticipated, this includes the current difficulties presented by COVID-19.

If a carrier experiences unanticipated technical difficulties that prevent the timely preparation and submission of the applicable data call information, the carrier may request an extension. The request must be submitted at least two weeks prior to the required due date. However, the data must be submitted by April 1, 2021, and any requests for extension may not exceed that date. Additionally, the request is only available for this year and extensions are not available for subsequent years.

A request for the hardship extension shall include, but is not limited to, the following: (1) the reason(s) for the requested time period of the extension; (2) the burden and expense that the carrier would incur if it was required to make a timely submission; (3) how is the carrier going to correct the reasons provided for requesting an extension by the extension deadline; (4) the carrier must specify a length of time for a requested extension, not to exceed April 1, 2021, and (5) the carrier's contact information, including email address, where the OIC will send notification of approval or denial of the request.

The hardship extension shall not be deemed granted until the OIC notifies the carrier in writing by email. If the OIC denies the request for an extension, the carrier shall file a full response to the data call by the required due date. If the OIC determines that the grant of the extension is appropriate, the OIC will notify the carrier via email. The OIC may determine that the full length of the requested extension does not qualify for the hardship extension and will notify the carrier if it does not approve the full request.

To request an extension, please email market.conduct@oic.wa.gov and include the information required to request an extension. If you have any questions, please send an email to NedG@oic.wa.gov.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Appendix C

ESSB 6404 Response Template

Each carrier was directed to complete the excel spreadsheet below for each of the following categories of health care service codes:

- Inpatient medical/surgical codes
- Outpatient medical/surgical codes
- Inpatient mental health and substance use disorder codes
- Outpatient mental health and substance use disorder codes
- Diabetes supplies and equipment codes
- Durable medical equipment codes

Column1	Service Descriptor	Codes with the highest total number of prior authorization requests during the previous plan year	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions
Code 1							
Code 2							
Code 3							
Code 4							
Code 5							
Code 6							
Code 7							
Code 8							
Code 9							
Code 10							

Column1	Service Descriptor	Codes with the highest percentage of approved prior authorization requests during the previous plan year	Total number of prior authorization requests for each code	Percentage of approved requests for each code	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions
Code 1							
Code 2							
Code 3							
Code 4							
Code 5							
Code 6							
Code 7							
Code 8							
Code 9							
Code 10							

Column1	Service Descriptor	Codes with the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal	Total number of prior authorization requests for each code	Percentage of requests initially denied and then subsequently	Average determination response time in hours for prior authorization requests - Expedited Decisions	Average determination response time in hours for prior authorization requests - Standard Decisions	Average determination response time in hours for prior authorization requests - Extenuating Circumstances Decisions
Code 1							
Code 2							
Code 3							
Code 4							
Code 5							
Code 6							
Code 7							
Code 8							
Code 9							
Code 10							

Appendix D

Carrier Responses (Sent as an Excel Doc separately)

Health Plan Prior Authorization Data Re