

WAC 284-43-2020 Drug utilization review—Generally. (1) These definitions apply to this section only:

(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 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. The program must include a method for reviewing and updating criteria. Issuers must make drug review criteria available upon request to a participating provider.

(3) The utilization review program must meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(4) The 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 is not accompanied by all necessary information, the issuer must tell the provider 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 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 hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or

(C) Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, the issuer must request that the provider submits additional information to make the prior authorization determination:

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

(II) The issuer must then approve or deny the request within forty-eight hours of the receipt of the requested additional information 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 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 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) 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.

[WSR 16-01-081, recodified as § 284-43-2020, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-420, filed 11/25/15, effective 7/1/16.]