

- 275-155-090 Conditions. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.
- 275-155-100 Application requests and approval for escorted leave. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.
- 275-155-110 Escort procedures. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.
- 275-155-120 Expenses. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.
- 275-155-130 Expenses—Paid by resident. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.
- 275-155-140 Expenses—Paid by department. [Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.] Decodified by 99-21-001, filed 10/6/99, effective 10/6/99.

Reviser's note: Later promulgation, see chapter 388-880 WAC.

WAC 275-155-005 through 275-155-140 Decodified.
See Disposition Table at beginning of this chapter.

Chapter 275-156 WAC

CIVIL COMMITMENT COST REIMBURSEMENT

WAC

275-156-005 through 275-156-040 Decodified.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 275-156-005 Purpose. [Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-010 Definitions. [Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-015 Limitation of funds. [Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-020 Maximum allowable reimbursement for civil commitment cost. [Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-025 Billing procedure. [Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-030 Exceptions. [Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-

- 275-156-035 030, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.
- 275-156-040 Audits. [Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.] Decodified by 99-21-002, filed 10/6/99, effective 10/6/99.

Reviser's note: Later promulgation, see chapter 388-885 WAC.

WAC 275-156-005 through 275-156-040 Decodified.
See Disposition Table at beginning of this chapter.

Title 284 WAC INSURANCE COMMISSIONER

Chapters

- 284-07 Requirements as to company reports and annual statements.
- 284-24 Rates.
- 284-43 Health carriers and health plans.
- 284-44 Health care services contractors—
Agents—Contract formats—Standards.
- 284-46 Health maintenance organizations.
- 284-50 Washington disability insurance regulations.
- 284-53 Standards for coverage of chemical dependency.
- 284-91 Health insurance access regulation.
- 284-96 Group and blanket disability insurance.

Chapter 284-07 WAC

REQUIREMENTS AS TO COMPANY REPORTS AND ANNUAL STATEMENTS

WAC

284-07-050 Annual statement instructions.

WAC 284-07-050 Annual statement instructions. (1)
For the purpose of this section, the following definitions shall apply:

(a) "Insurer" shall have the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW.

(b) "Insurance" shall have the same meaning as set forth in RCW 48.01.040. It also includes prepayment of health care services as set forth in RCW 48.44.010(3) and prepayment of comprehensive health care services as set forth in RCW 48.46.020(1).

(2) Each authorized insurer is required to file with the commissioner an annual statement for the previous calendar year in the general form and context as promulgated by the National Association of Insurance Commissioners (NAIC) for the kinds of insurance to be reported upon, and shall also file a copy thereof with the NAIC. To effectuate RCW

48.05.250, 48.05.400, 48.44.095 and 48.46.080 and to enhance consistency in the accounting treatment accorded various kinds of insurance transactions, the valuation of assets, and related matters, insurers shall adhere to the appropriate Annual Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC.

(3) This section does not relieve an insurer from its obligation to comply with specific requirements of the insurance code or rules thereunder.

(4) Number of statements:

(a) For domestic insurers, the statements are to be filed in triplicate to assist with public viewing and copying. Two statements must be permanently bound on the left side. The third statement must be unbound. The statements are to be filed in the Olympia office.

(b) For foreign insurers, except for health care service contractors and health maintenance organizations, one statement shall be filed in the Olympia office. For health care service contractors and health maintenance organizations, two left side permanently bound and one unbound statement shall be filed in the Olympia office to assist with public viewing and copying.

(5) Each domestic insurer shall file quarterly reports of its financial condition with the commissioner. Each foreign insurer shall file quarterly reports of its financial condition with the NAIC. The commissioner may require a foreign insurer to file quarterly reports with the commissioner whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the foreign insurer. The reports shall be filed in the commissioner's office not later than the forty-fifth day after the end of the insurer's calendar quarters. Such quarterly reports shall be in the form and content as promulgated by the NAIC for quarterly reporting by insurers, shall be prepared according to appropriate Annual and Quarterly Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC and shall be supplemented with additional information required by this title and by the commissioner. The statement is to be completed and filed in the same manner and places as the annual statement. Quarterly reports for the fourth quarter are not required.

(6) As a part of any investigation by the commissioner, the commissioner may require an insurer to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the insurer. Monthly financial statements shall be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. Such monthly financial reports shall be the internal financial statements of the company. In addition, the commissioner may require these internal financial statements to be accompanied by a schedule converting the financial statements to reflect financial position according to statutory accounting practices and submitted in a form using the same format and designation as the insurer's quarterly financial reports of insurers.

(7) Health care service contractors shall use the Hospital, Medical, Dental Service or Indemnity Corporation's Statement Form promulgated by the NAIC for their statutory filings.

(8) Each health care service contractor's and health maintenance organization's annual statement shall be accompanied by a monthly enrollment data form (IC-16-HC/IC-15-HMO) and additional data statement form (IC-13A-HC/IC-14-HMO).

(9) An insurer who on December 31, 1996, has not previously filed its annual or quarterly statements with the NAIC, shall comply with this rule for the year ending December 31, 1996, and each year thereafter. To enhance the intrastate and interstate surveillance of the insurer's financial condition earlier application is permitted.

(10) The commissioner may allow a reasonable extension of the time within which such financial statements shall be filed.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 99-16-035 (Matter No. R - 99-3), § 284-07-050, filed 7/28/99, effective 8/28/99; 96-17-079 (Matter No. R 95-18), § 284-07-050, filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-050, filed 9/9/92, effective 10/10/92.]

Chapter 284-24 WAC RATES

WAC

284-24-120

Suspension of rate filing requirements—Large commercial accounts.

WAC 284-24-120 Suspension of rate filing requirements—Large commercial accounts. (1) Under RCW 48.19.080, the rate filing requirements in chapter 48.19 RCW are suspended with respect to large commercial property casualty accounts.

(2) For purposes of this section, "large commercial property casualty account" means insurance coverage that:

(a) Pertains to a business, nonprofit organization, or public entity;

(b) Involves the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, 48.11.070, and/or 48.11.080; and

(c) Has an estimated annual collected premium of \$25,000 or more, excluding workers compensation insurance issued by the department of labor and industries and types of insurance listed in subsection (6) of this section.

(3) Before an insurer issues coverage in reliance on this section, the insurer or its agent shall notify the insured in writing that the rates have not been and will not be filed for the commissioner's approval.

(4) Property rates used on large commercial property casualty accounts will not be audited by the Washington Insurance Examining Bureau under WAC 284-20-006.

(5) The commissioner retains the right and ability to examine the rates used on large commercial property casualty accounts to ascertain whether they meet the requirements of RCW 48.19.020 and other statutes. The insurer shall maintain records supporting the rating and premium determination of each policy issued in reliance on this section. These records shall be retained by the insurer for a minimum of three years and made available at all reasonable times for the commissioner's examination.

(6) Subsection (1) of this section does not apply to:

- (a) Professional liability insurance, including medical malpractice insurance;
- (b) Directors' and officers' liability insurance purchased by individuals;
- (c) Motor vehicle service contract reimbursement insurance, as defined in RCW 48.96.010(4); and
- (d) Master policies under which certificates of coverage are issued to individual consumers, households, businesses, or other organizations.

(7) If this subsection is not amended, the provisions of this section shall expire on December 31, 2001.

[Statutory Authority: RCW 48.02.060 and 48.19.080. 99-23-068 (Matter No. R 99-5), § 284-24-120, filed 11/15/99, effective 12/16/99.]

Chapter 284-43 WAC
HEALTH CARRIERS AND HEALTH PLANS

WAC

284-43-130	Definitions.
284-43-205	Every category of health care providers.
284-43-320	Provider contracts—Standards—Hold harmless provisions.
284-43-321	Provider contracts—Terms and conditions of payment.
284-43-322	Provider contracts—Dispute resolution process.
284-43-324	Provider contracts—Audit guidelines.
284-43-330	Participating provider—Filing and approval.
284-43-331	Effective date.
284-43-610	Definitions.
284-43-620	Procedures for health care service review decisions.
284-43-810	Coverage for mental health services.

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

- (1) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.
- (2) "Covered person" means an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.
- (3) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
- (4) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.
- (5) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.
- (6) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings.

(7) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

- (a) Denial of health care services or payment for health care services; or
- (b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

(8) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(9) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(10) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

(11) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

- (a) Long-term care insurance governed by chapter 48.84 RCW;
- (b) Medicare supplemental health insurance governed by chapter 48.66 RCW;
- (c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;
- (d) Disability income;
- (e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;
- (f) Workers' compensation coverage;
- (g) Accident only coverage;
- (h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;
- (i) Employer-sponsored self-funded health plans;
- (j) Dental only and vision only coverage; and
- (k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(12) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(13) "Medically necessary" or "medical necessity" in regard to mental health services is a carrier determination as to whether a health service is a covered benefit if the service

is consistent with generally recognized standards within a relevant health profession.

(14) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(15) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(16) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(17) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology*, published by the American Medical Association.

(18) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(19) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(20) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(21) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(22) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(23) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050,

48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Order R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

WAC 284-43-205 Every category of health care providers. (1) To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the carrier's standards pursuant to RCW 48.43.045 (1)(b). For example, if the BHP provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) may not be excluded from the network.

(2) RCW 48.43.045 (1)(b) permits health carriers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, health carriers may not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers. However, health plans may not contain unreasonable limits, and may not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(b).

(4) This section does not prohibit health plans from using restricted networks. Health carriers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. A health carrier is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan. Health plans that use "gatekeepers" for access to specialist providers may use them for access to specified categories of providers.

(5) Health carriers may not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW

48.43.045 or this section, or any part thereof, for good cause shown.

(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.]

WAC 284-43-320 Provider contracts—Standards—

Hold harmless provisions. The execution of a contract by a health carrier shall not relieve the health carrier of its obligations to any covered person for the provision of health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts shall be in writing and available for review upon request by the commissioner.

(1) A health carrier shall establish a mechanism by which its participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits.

Nothing contained in a participating provider or a participating facility contract may have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the contract and a health plan, the benefits, terms, and conditions of the health plan shall govern with respect to coverage provided to covered persons.

(2) Each participating provider and participating facility contract shall contain the following provisions or variations approved by the commissioner:

(a) "{Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of carrier}, {name of carrier's} insolvency, or breach of this contract shall {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than {name of carrier}, for services provided pursuant to this contract. This provision shall not prohibit collection of {deductibles, copayments, coinsurance, and/or noncovered services}, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan."

(b) "{Name of provider or facility} agrees, in the event of {name of carrier's} insolvency, to continue to provide the services promised in this contract to covered persons of {name of carrier} for the duration of the period for which premiums on behalf of the covered person were paid to {Name of carrier} or until the covered person's discharge from inpatient facilities, whichever time is greater."

(c) "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the covered person's health plan."

(d) "{Name of provider or facility} may not bill the covered person for covered services (except for deductibles,

copayments, or coinsurance) where {name of carrier} denies payments because the provider or facility has failed to comply with the terms or conditions of this contract."

(e) "{Name of provider or facility} further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection {or identifying citations appropriate to the contract form} shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {name of carrier's} covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {name of provider or facility} and covered persons or persons acting on their behalf."

(f) "If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to covered persons of {name of carrier} with the expectation of receiving payment directly or indirectly from {name of carrier}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

(3) The contract shall inform participating providers and facilities that willfully collecting or attempting to collect an amount from a covered person knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

(4) A health carrier shall notify participating providers and facilities of their responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

Documents, procedures, and other administrative policies and programs referenced in the contract must be available for review by the provider or facility prior to contracting. Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes. No change to the contract may be made retroactive without the express consent of the provider or facility.

(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:

(a) "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this

section shall be construed to authorize providers to bind health carriers to pay for any service."

(b) "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

(6) A health carrier shall require participating 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 covered persons subject to applicable state and federal laws related to the confidentiality of medical or health records.

(7) A health carrier and participating provider and facility shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, that carrier shall make a good faith effort to assure that notice is provided to all covered persons who are patients of that primary care provider.

(8) A health carrier is responsible for ensuring that participating providers and facilities furnish covered services to covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(9) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

(10) The following provision is a restatement of a statutory requirement found in RCW 48.43.085: "Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan."

(11) Every participating provider contract shall contain procedures for the fair resolution of disputes arising out of the contract.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Order R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

WAC 284-43-321 Provider contracts—Terms and conditions of payment. (1) Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.

(2)(a) For health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

(b) The receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

(c) The carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(e) When the carrier issues payment in either the provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the provider or facility first and the covered person second.

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

(5) Every carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the carrier or acting pursuant to carrier standards or requirements complies with these billing and claim payment standards.

(6) These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities or covered persons, or instances where

the carrier has not been granted reasonable access to information under the provider's or facility's control.

(7) Providers, facilities, and carriers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.]

WAC 284-43-322 Provider contracts—Dispute resolution process. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider or facility contract shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of this section.

(1) A dispute resolution process may include an initial informal process but must include a formal process for resolution of all contract disputes.

(2) A carrier may have different types of dispute resolution processes as necessary for specialized concerns such as provider credentialing or as otherwise required by law. For example, disputes over health plan coverage of health care services are subject to the grievance procedures established for covered persons.

(3) Carriers must allow not less than thirty days after the action giving rise to a dispute for providers and facilities to complain and initiate the dispute resolution process.

(4) Carriers may not require alternative dispute resolution to the exclusion of judicial remedies; however, carriers may require alternative dispute resolution prior to judicial remedies.

(5) Carriers must render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, the carrier must render a decision within sixty days of the complaint.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.]

WAC 284-43-324 Provider contracts—Audit guidelines. (1) Provider and facility contracts may not contain provisions that grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier's right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

(2) Provider and facility contract provisions granting the carrier access to medical records for audit purposes must be limited to only that necessary to perform the audit.

(3) Provider and facility contracts may not contain billing audit standards that are not mutual. For example, if the carrier grants itself the right to audit hospital billing records, then the hospital has the right to audit carrier denials of the hospital's claims.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.]

WAC 284-43-330 Participating provider—Filing and approval. (1) Beginning May 1, 1998, a health carrier shall file with the commissioner fifteen working days prior to use sample contract forms proposed for use with its participating providers and facilities. A health carrier need not submit contract provisions governing payment rates, amounts, or similar proprietary information that would indicate provider or facility compensation.

(2) A health carrier shall submit material changes to a sample contract form to the commissioner fifteen working days prior to use. Carriers shall indicate in the filing whether any change affects a provision required by this chapter. All changes to contracts must be indicated through strike outs for deletions and underlines for new material. Alternatively, carriers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes. Changes not affecting a provision required by this chapter are deemed approved upon filing.

(3) If the commissioner takes no action within fifteen working days after submission of a sample contract or a material change to a sample contract form by a health carrier, the change or form is deemed approved except that the commissioner may extend the approval period an additional fifteen working days upon giving notice before the expiration of the initial fifteen-day period. Approval may be subsequently withdrawn for cause.

(4) The health carrier shall maintain provider and facility contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Order R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.]

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules shall comply with these rules no later than July 1, 2000.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules shall be amended upon renewal to comply with these rules, and all such contracts shall conform to these provisions no later than January 1, 2001. The commissioner may extend the January 1, 2001, deadline for a health carrier for an additional six months, if the health carrier makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the health carrier expects to be in compliance (no more than six months beyond January 1, 2001).

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.]

WAC 284-43-610 Definitions. For the purposes of this subchapter:

(1) "Adverse determination" means a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility. Such term does not include a decision affecting payment or coverage after the service or benefit has been provided.

(2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, health care service management computer software, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-610, filed 11/29/99, effective 12/30/99.]

WAC 284-43-620 Procedures for health care service review decisions. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the coverage person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay would jeopardize the covered person's life or materially jeopardize the person's health, the carrier shall presume the need for expeditious review.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of a covered person appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the covered person or a provider acting on behalf of the covered person.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the covered person a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written state-

ment of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

WAC 284-43-810 Coverage for mental health services. (1) The commissioner may disapprove any contract issued or renewed after April 1, 2000, that includes coverage for mental health services, and those services are advertised, if it does not include the following statement:

MENTAL HEALTH SERVICES AND YOUR RIGHTS

(Health Carrier Name) and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact us (the health carrier) at xxx-xxx-xxxx (current phone number).

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at xxx-xxx-xxxx (current phone number suggested by State Health Department).

(2) The commissioner may disapprove any contract issued or renewed after April 1, 2000, that includes coverage for mental health services, and those services are advertised, if it does not pose and respond in writing to the following questions in language that complies with WAC 284-50-010 through 284-50-230 in or accompanying an invitation to contract which is given to each prospective contract holder with an offer to provide for distribution to prospective enrollees prior to enrollment.

(a) **"What are the steps that must be taken to have outpatient mental health services paid for by my plan?"**

Yes No

Direct self referral to a participating provider, with no prior authorization or approval.

Primary care provider referral required; Primary care provider may determine the number of visits.

Preauthorization, predetermination of medical necessity, preverification of benefits and eligibility or referral required.

(b) "What information about my mental condition will anyone other than my mental health provider see?"

- No information, other than your diagnostic category and number of treatments you received.
Diagnostic details.
Treatment codes.
Treatment plans, including expected outcomes.
Progress notes.
Other.

(c) "Do I have to pay a higher co-pay, deductible or other charges than I pay for my other covered medical services to get mental health services under this plan?"

- Same Less More
Deductibles.
Co-pays.
Co-insurance.
Other cost sharing.

(d) "What is the maximum number of medically necessary in-patient days and out-patient visits I can get each year under this plan?"

- Inpatient Outpatient
Days Visits
Less than ten.
Eleven to twenty.
Twenty-one to thirty.
More than thirty.
Other.

(e) "What is the average number of outpatient visits this plan pays for people who have been provided mental health services?" (Note to carriers: This response must state the average outpatient visits per enrollee requesting these services during the most recent year for which data is available. This time period may begin no more than thirty-six months prior to the issue date of the policy being sold.)

- Less than ten.
Eleven to twenty.
Twenty-one to thirty.
More than thirty.
Other.

(f) "In which of the following circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than medical necessity?"

- Diagnostic testing to determine if a mental disorder exists.
A mental disorder has a congenital or physical basis, such as Tourette's Syndrome, or may be partially covered under the medical services portion of the health plan.
A court orders treatment.
Treatment surrounding self inflicted harm, such as a suicide attempt.
There are diagnosed learning disabilities.
There is a diagnosed eating disorder.
There is a diagnosed mental disorder related to sexual functioning, or a sex change.
Couples or marriage therapy.

Custodial care.

(g) "What is this plan's most common goal in financing treatment in adults? In children?"

- Stabilization and symptom management.
Return to previous functioning.
Ongoing maintenance for long-term illness.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-810, filed 9/8/99, effective 10/9/99.]

Chapter 284-44 WAC

HEALTH CARE SERVICES CONTRACTORS—AGENTS—CONTRACT FORMATS—STANDARDS

WAC

284-44-043

Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

WAC 284-44-043 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1)

Every health care service contract which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the contract and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health care service contractor specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the contract and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the contract and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon

written request in all instances and may not be withheld as proprietary.

(3) Every health care service contractor that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the contract and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health care service contractor must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health care service contractor in each contract and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the health care service contractor's decision and delay would jeopardize the covered person's life or health, the health care service contractor must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Mat-

ter No. R 98-17), § 284-44-043, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. 92-21-099 (Order 92-15), § 284-44-043, filed 10/21/92, effective 11/21/92.]

Chapter 284-46 WAC

HEALTH MAINTENANCE ORGANIZATIONS

WAC

284-46-507

Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

WAC 284-46-507 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every health maintenance agreement which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the agreement and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health maintenance organization specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the agreement and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the agreement or any certificate of coverage thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health maintenance organization that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the agreement and any certificate of coverage thereunder, because of an experimental or investigational exclusion or

limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health maintenance organization must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health maintenance organization in each agreement and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitations.

(5) Whenever a covered person appeals the decision of the health maintenance organization and delay would jeopardize the covered person's life or health, the health maintenance organization must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-46-507, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.46.200. 92-21-098 (Order 92-14), § 284-46-507, filed 10/21/92, effective 11/21/92.]

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

284-50-377

Experimental and investigational prescriptions, treatments, procedures, or service—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

WAC 284-50-377 Experimental and investigational prescriptions, treatments, procedures, or service—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1)

Every individual disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the individual disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy. As an example, and not by way of limitation, the requirement to set forth criteria in the policy may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every individual disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by

name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every individual disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the individual disability insurer in each policy which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the insurer must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-50-377, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. 92-21-101 (Order R 92-17), § 284-50-377, filed 10/21/92, effective 11/21/92.]

Chapter 284-53 WAC

STANDARDS FOR COVERAGE OF CHEMICAL DEPENDENCY

WAC

284-53-005
284-53-010

Definitions.
Standards for coverage of chemical dependency.

WAC 284-53-005 Definitions. (1) "Chronic illnesses" include, but are not limited to, heart disease, diabetes, chronic obstructive pulmonary disease, and chemical dependency.

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(2) "Medically necessary" or "medical necessity," with respect to chemical dependency coverage, means indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II* as published in 1996 by the American Society of Addiction Medicine.

(3) Other terms used in this chapter, but not specifically defined here, shall have the meanings given in WAC 284-43-130 or, if not defined there, in WAC 284-50-030.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350. 99-16-005 (Matter No. R 97-8), § 284-53-005, filed 7/22/99, effective 8/22/99.]

WAC 284-53-010 Standards for coverage of chemical dependency. Contractual provisions in any policy issued or renewed on or after January 1, 2000, for chemical dependency required by RCW 48.21.180, 48.44.240, or 48.46.350 shall meet the following standards and administrative requirements.

(1) Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and so long as a patient is not yet enrolled in other chemical dependency treatment, detoxification may not be included when calculating payments within the chemical dependency payment minimum required in this chapter.

(2) The coverage for chemical dependency shall provide payment for reasonable charges for any medically necessary treatment and supporting services provided to an enrollee by an "approved treatment program" approved under RCW 70.96A.020(3). In addition, medically necessary detoxification services may also be provided in hospitals licensed according to chapter 70.41 RCW.

(3) Except to the extent prohibited by this chapter, the chemical dependency coverage may be limited by provisions of the contract that are applicable to other benefits or services for other chronic illnesses or disease generally including, but not limited to, provisions relating to enrollee point of service cost sharing. However, coverage shall not be denied by reason of contract provisions which are not pertinent to the treatment of chemical dependency, such as provisions requiring a treatment program to have surgical facilities or approval by the joint commission on accreditation of hospitals, that there be a physician in attendance, or that the exact date of onset be known.

(4)(a) The minimum benefits for chemical dependency treatment and supporting services shall be no less than ten thousand dollars, exclusive of all enrollee point of service cost-sharing amounts in any consecutive twenty-four-month period.

(b) The minimum benefit specified in this subsection must be adjusted by a carrier in any of its contracts for which a new or revised form is filed with the commissioner. The adjustment must correspond with the change in the medical care component of the consumer price index for all urban consumers for the *Seattle Standard Metropolitan Statistical Area* compiled by the Bureau of Labor statistics, United States Department of Labor. The base year for the computation shall be 1999.

(5) Contract provisions subject to this rule:

(a) Shall not impose waiting periods or preexisting condition limitations on chemical dependency coverage, except

that a carrier may impose no longer than a three month preexisting condition limitation for chemical dependency treatment and supporting services to the extent that a preexisting condition limitation is imposed for other chronic illnesses.

(b) Shall not deny reasonable benefits for actual treatment and services rendered solely because a course of treatment was interrupted or was not completed.

(c) May limit coverage to specific facilities but only if the carrier provides or contracts for the provision of approved treatment programs under RCW 70.96A.020 which alone or in combination offer both inpatient and outpatient care and which comply with network adequacy requirements established in WAC 284-43-200. This right to limit coverage to specific facilities permits a carrier to limit diagnosis and treatment to that rendered by itself or by a facility to which it makes referrals, but, in either case, only if the facility is or part of an approved treatment program under RCW 70.96A.020.

(d) Except in the case of detoxification services, may require prenotification in all reasonable situations; may also require a second opinion if such second opinion is required under the contract generally for other chronic illnesses. Prenotification with respect to medically necessary detoxification services is not reasonable.

(6) In situations where an enrollee is under court order to undergo a chemical dependency assessment or treatment, or in situations related to deferral of prosecution, deferral of sentencing or suspended sentencing, or in situations pertaining to motor vehicle driving rights and the Washington state department of licensing, the carrier may require the enrollee to furnish at the enrollee's expense no less than ten and no more than thirty working days before treatment is to begin, an initial assessment of the need for chemical dependency treatment and a treatment plan, made by an individual of the enrollee's choice who is a chemical dependency counselor as defined in chapter 440-22 WAC employed by an approved treatment program under RCW 70.96A.020 or licensed under chapter 18.57 or 18.71 RCW to enable the carrier to make its own evaluation of medical necessity prior to scheduled treatment. Nothing in this chapter may be construed to require a carrier to pay for court ordered chemical dependency treatment that is not medically necessary, nor may anything in this chapter be construed to relieve a carrier from its obligations to pay for court ordered chemical dependency treatment when it is medically necessary.

(7) Except as determined not to be medically necessary or otherwise specifically provided in this chapter, contractual provisions subject to this section and the administration of such provisions shall not use definitions, predetermination procedures or other prior approval requirements, or other provisions, requirements or procedures, which restrict access to treatment, continuity of care or payment of claims.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350. 99-16-005 (Matter No. R 97-8), § 284-53-010, filed 7/22/99, effective 8/22/99. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-050 (Order R 87-10), § 284-53-010, filed 8/31/87, effective 1/1/88; 86-18-027 (Order R 86-2), § 284-53-010, filed 8/27/86, effective 1/1/87.]

Chapter 284-91 WAC

HEALTH INSURANCE ACCESS REGULATION

WAC

284-91-060

Eligibility in counties without commercially available coverage equivalent to pool coverage.

WAC 284-91-060 Eligibility in counties without commercially available coverage equivalent to pool coverage.

(1) Evidence of rejection under RCW 48.41.100 shall be waived by the pool for any person unable to obtain an individual health plan as defined in RCW 48.43.005(18) because the person resides in a county of this state where no member offers to the public an individual health plan.

(2) In accordance with RCW 48.41.180, every member shall provide a notice and application for pool coverage to every person who applies for and is denied for any reason, an individual health plan. This includes the reason that the member has decided to reject all new applicants for individual health plan coverage state-wide or within any county.

[Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170 and 48.41.100. 99-18-039 (Matter No. R 99-4), § 284-91-060, filed 8/25/99, effective 9/25/99.]

Chapter 284-96 WAC

GROUP AND BLANKET DISABILITY INSURANCE

WAC

284-96-015

Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.

WAC 284-96-015 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every group disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the group disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the policy and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Wash-

ington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every group disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every group disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the group disability insurer in each policy and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the group disability insurer must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-96-015, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. 92-21-100 (Order R 92-16), § 284-96-015, filed 10/21/92, effective 11/21/92.]

Title 286 WAC

INTERAGENCY COMMITTEE FOR OUTDOOR RECREATION

Chapters

286-26 Nonhighway road and off-road vehicle funds.

Chapter 286-26 WAC

NONHIGHWAY ROAD AND OFF-ROAD VEHICLE FUNDS

WAC

286-26-100 Development projects—Conversion to other uses.

WAC 286-26-100 Development projects—Conversion to other uses. (1) Without prior approval of the committee, a facility developed with money granted by the committee shall not be converted to a use other than that for which funds were originally approved.

(2) The committee shall only approve such a conversion under conditions which assure that:

(a) All practical alternatives to the conversion have been evaluated and rejected on a sound basis;

(b) A new development, in the spirit of WAC 286-13-080 ("...aid through the committee is intended to supplement the existing capacity of a sponsor..."), will serve as a replacement which:

(i) Is of reasonably equivalent recreation utility and location;

(ii) Will be administered by the same political jurisdiction as the converted development;

(iii) Will satisfy need(s) identified in the sponsor's NOVA plan (see WAC 286-26-080); and

(iv) Includes only elements eligible under the committee's program from which funds were originally allocated.

(3) A master agreement signed by the parties shall control the provision of funds granted by the committee for facility developments to any federal agency sponsor.

[Statutory Authority: RCW 46.09.240. 99-16-009, § 286-26-100, filed 7/22/99, effective 8/22/99. Statutory Authority: RCW 43.98A.060(1),