

WAC 284-43-2000 Health care services utilization review—Generally. (1) These definitions apply to this section:

(a) "Concurrent care review request" means any request for an extension of a previously authorized inpatient stay or a previously authorized ongoing outpatient service, e.g., physical therapy, home health, etc.

(b) "Postservice review request" means any request for approval of care or treatment that has already been received by the enrollee.

(2) Each issuer must maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Issuers must make clinical review criteria available upon request to participating providers and facilities. An issuer need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

(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 and must have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(4) Each issuer when conducting utilization review must:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all enrollees reviewed;

(e) Require only the section(s) of the medical record during concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For concurrent review, base review determinations solely on the medical information obtained by the issuer at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the provider or facility at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider or facility;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the issuer is materially different from that which was reasonably available at the time of the original determination.

(5) Each issuer must reimburse reasonable costs of medical record duplication for reviews.

(6) Each issuer must have written procedures to assure that reviews and second opinions are conducted in a timely manner.

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

(b) If the review request from the provider or facility is not accompanied by all necessary information, the issuer must tell the provider or facility 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 review determination and notification must be no less favorable than federal Department of Labor standards, as follows. For urgent inpatient services that require concurrent review, the time frame is as soon as possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments. For postservice review requests, within thirty calendar days.

(c) Notification of the determination must be provided as follows:

(i) Information about whether a request was approved or denied must be made available to the provider or facility, and enrollee. Issuers must at a minimum make the information available on their website or from their call center.

(ii) Whenever there is an adverse determination the issuer must notify the provider or facility and the enrollee. The issuer must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means.

(d) As appropriate to the type of request, notification must include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(e) The frequency of reviews for the extension of initial determinations must be based on the severity or complexity of the enrollee's condition or on necessary treatment and discharge planning activity.

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

[Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, and 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-2000, filed 6/5/17, effective 1/1/18. Statutory Authority: RCW 48.02.060, 48.43.510, and 48.165.0301. WSR 16-11-074 (Matter No. R 2016-02), § 284-43-2000, filed 5/16/16, effective 1/1/17. WSR 16-01-081, recodified as § 284-43-2000, 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), § 284-43-410, filed 11/25/15, effective 7/1/16. Statutory Authority: RCW 48.02.060, 48.43.530, P.L. 111-148 (2010, as amended) and regulations issued on June 24, 2011, amending 45 C.F.R. Part 147. WSR 11-24-004

(Matter No. R 2011-18), § 284-43-410, filed 11/28/11, effective 12/29/11. Statutory Authority: RCW 48.02.060 and 48.43.520. WSR 10-23-051 (Matter No. R 2009-19), § 284-43-410, filed 11/10/10, effective 12/11/10. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]