WAC 284-83-320 Standards for the issuer's timely review of a claim denial. The following administrative, business, and operational standards must be used by issuers to ensure timely review of a claim denial.

(1) Issuers must have a fully operational, comprehensive claims denial review process.

(2) Issuers must implement procedures for registering and responding to oral and written requests for review of a claim denial in a timely and thorough manner.

(3) Issuers must provide written notice to the insured, to the insured's designated representative, and to the insured's provider of its decision 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 health care facility or any other long-term care services or benefits.

(4) Issuers must process as an appeal an enrollee's written or oral request that the issuer reconsider its decision 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 health care facility. The issuer must not require that the insured file a complaint prior to seeking appeal of any such decision.

(5) The issuer must:

(a) Provide written notice to the insured when the appeal is received;

(b) Assist the insured with the appeal process;

(c) Make its decision regarding the appeal within thirty days after the date the appeal is received, except when a determination is made that the issuer's action must be expedited;

(d) Cooperate with a representative authorized in writing by the insured;

(e) Consider all information submitted by the insured;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the insured and, with the permission of the insured, to the insured's providers, that:

(i) Explains the issuer's decision and the supporting coverage or clinical reasons for the decision; and

(ii) If applicable, explains any further appeal process, including, if applicable, information about how to exercise the insured's rights to a second opinion and how to continue receiving or reinstate services.

(6) An appeal must be expedited if the insured's provider or the insured's medical director reasonably determines that following the appeal process, response timelines could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer.

(7) If the insured requests that the issuer reconsider its decision to modify, reduce, or terminate an otherwise covered health care service, and if the issuer's decision is based on the issuer's determination that the health service or level of health service is no longer covered, the issuer must continue to provide the health service until the appeal is resolved.

(8) Issuers must provide a clear explanation of their grievance processes and procedures at the time of application and upon request of the insured.

(9) Issuers must ensure that their grievance processes and procedures are accessible to insureds who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Issuers must track each appeal until final resolution and, upon request, make available to the commissioner a log of all appeals and grievances.

(11) Issuers must establish a process to identify and track problems encountered by enrollees when filing claims denials and, where appropriate, to make reasonable modifications to their appeals and grievance processes and procedures.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-83-320, filed 11/24/08, effective 12/25/08.]