WAC 284-43-3110 Internal review of adverse benefit determinations. An appellant seeking review of an adverse benefit determination must use the carrier's review process. Each carrier must include the opportunity for internal review of an adverse benefit determination in its review process. Treating providers may seek expedited review on a patient's behalf, regardless of whether the provider is affiliated with the carrier on a contracted basis.

(1) When a carrier receives a written request for review, the carrier must reconsider the adverse benefit determination. The carrier must notify the appellant of the review decision within fourteen days of receipt of the request for review, unless the adverse benefit determination involves an experimental or investigational treatment. The carrier must notify the appellant of the review decision within twenty days of receipt of the request for review when the adverse benefit determination involves an experimental or investigational treatment.

(2) For good cause, a carrier may extend the time it takes to make a review determination by up to sixteen additional days without the appellant's written consent, and must notify appellant of the extension and the reason for the extension. The carrier may request further extension of its response time only if the appellant consents to a specific request for a further extension, the consent is reduced to writing, and includes a specific agreed-upon date for determination. In its request for the appellant's consent, the carrier must explain that waiver of the response time is not compulsory.

(3) The carrier must provide the appellant with any new or additional evidence or rationale considered, whether relied upon, generated by, or at the direction of the carrier in connection with the claim. The evidence or rationale must be provided free of charge to the appellant and sufficiently in advance of the date the notice of final internal review must be provided. The purpose of this requirement is to ensure the appellant has a reasonable opportunity to respond prior to that date. If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the carrier and health plan must extend the determination date for a reasonable amount of time, which may not be less than two days.

(4) A carrier's review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including information and records obtained through a second opinion. An appellant has the right to review the carrier and health plan's file and obtain a free copy of all documents, records, and information relevant to any claim that is the subject of the determination being appealed.

(5) The internal review process must include the requirement that the carrier affirmatively review and investigate the appealed determination, and consider all information submitted by the appellant prior to issuing a determination.

(6) Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination that is within the clinical standard of care for an appellant's disease or condition.

(7) The internal review process for group health plans may be administered so that an appellant must file two internal requests for

review prior to bringing a civil action. For individual health plans, a carrier must provide for only one level of internal review before issuing a final determination, and may not require two levels of internal review.

(8) A rescission of coverage is an adverse benefit determination for which review may be requested.

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