WAC 284-43-3030 Review of adverse benefit determinations—Generally. (1) Each carrier must establish and implement a comprehensive process for the review of adverse benefit determinations. The process must offer an appellant the opportunity for both internal review and external review of an adverse benefit determination. The process must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required by this chapter.

(2) Neither a carrier nor a health plan may take or threaten to take any punitive action against a provider acting on behalf of or in support of an appellant.

(3) When the appeal is related to services the appellant is currently receiving as an inpatient, or for which a continuous course of treatment is medically necessary, coverage for those services must be continued while an adverse benefit determination is reviewed. Appellants must be notified that they may be responsible for the cost of services if the adverse benefit determination is upheld.

(4) A carrier must accept a request for internal review of an adverse benefit determination if the request is received within one hundred eighty days of the appellant's receipt of a determination under the plan. A carrier must notify an appellant of its receipt of the request within seventy-two hours of receiving the request.

(5) Each carrier and health plan must maintain a log of each adverse benefit determination review, its resolution, and the dates of receipt, notification, and determination.

(a) The carrier must make its review log available to the commissioner upon request in a form accessible by the commissioner. The log must be maintained by the carrier for a six-year period.

(b) Each carrier must identify, evaluate, and make available to the commissioner data and reports on trends in reviews for at least a six-year time frame, including the data on the number of adverse benefit determination reviews, the subject matter of the reviews and their outcome.

(c) When a carrier resolves issues related to an adverse benefit determination over the phone, without receiving a formal request for review, the carrier must include in these resolutions in its review log. A carrier's actions that are not in response to a member's call regarding an adverse benefit determination do not need to be included in the adverse benefit determination review log.

[WSR 16-01-081, recodified as § 284-43-3030, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.525, 48.43.530, 48.43.535, and The Patient Protection and Affordable Care Act, P.L. 111-148, as amended (2010). WSR 12-23-005 (Matter No. R 2011-11), § 284-43-510, filed 11/7/12, effective 11/20/12.]