
SUBSTITUTE HOUSE BILL 1566

State of Washington

69th Legislature

2025 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Rule, Marshall, Shavers, Pollet, and Kloba)

READ FIRST TIME 02/21/25.

1 AN ACT Relating to making improvements to transparency and
2 accountability in the prior authorization determination process;
3 amending RCW 48.43.830, 74.09.840, 41.05.845, 48.43.525, and
4 48.43.0161; and creating a new section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that health
7 insurance carriers, health plans, and managed care organizations are
8 the decision makers for the type and level of care covered for an
9 enrollee's health care benefits and are not responsible for
10 determining or altering an enrollee's diagnosis or treatment plan. It
11 is not always transparent who the decision maker is or how decisions
12 are made in determining enrollee coverage for treatment, prescription
13 drugs, or services. Artificial intelligence is being increasingly
14 utilized by carriers, health plans, and managed care organizations to
15 make or aid in decisions about medical necessity and coverage of
16 provider-recommended treatment.

17 (2) It is the intent of the legislature to increase transparency
18 in the prior authorization process for health care coverage decisions
19 and to ensure licensed physicians and licensed health professionals
20 remain responsible for making determinations about coverage for
21 treatment, prescription drugs, and services that are medically

1 necessary. If artificial intelligence tools are used to aid in the
2 decision-making process, standards must be put in place to ensure
3 these tools are not used to make inappropriate determinations that
4 could impact the health of an enrollee.

5 **Sec. 2.** RCW 48.43.830 and 2023 c 382 s 1 are each amended to
6 read as follows:

7 (1) Each carrier offering a health plan issued or renewed on or
8 after January 1, 2024, shall comply with the following standards
9 related to prior authorization for health care services and
10 prescription drugs:

11 (a) The carrier shall meet the following time frames for prior
12 authorization determinations and notifications to a participating
13 provider or facility that submits the prior authorization request
14 through an electronic prior authorization process, as designated by
15 each carrier:

16 (i) For electronic standard prior authorization requests, the
17 carrier shall make a decision and notify the provider or facility of
18 the results of the decision within three calendar days, excluding
19 holidays, of submission of an electronic prior authorization request
20 by the provider or facility that contains the necessary information
21 to make a determination. If insufficient information has been
22 provided to the carrier to make a decision, the carrier shall request
23 any additional information from the provider or facility within one
24 calendar day of submission of the electronic prior authorization
25 request.

26 (ii) For electronic expedited prior authorization requests, the
27 carrier shall make a decision and notify the provider or facility of
28 the results of the decision within one calendar day of submission of
29 an electronic prior authorization request by the provider or facility
30 that contains the necessary information to make a determination. If
31 insufficient information has been provided to the carrier to make a
32 decision, the carrier shall request any additional information from
33 the provider or facility within one calendar day of submission of the
34 electronic prior authorization request.

35 (b) The carrier shall meet the following time frames for prior
36 authorization determinations and notifications to a participating
37 provider or facility that submits the prior authorization request
38 through a process other than an electronic prior authorization
39 process:

1 (i) For nonelectronic standard prior authorization requests, the
2 carrier shall make a decision and notify the provider or facility of
3 the results of the decision within five calendar days of submission
4 of a nonelectronic prior authorization request by the provider or
5 facility that contains the necessary information to make a
6 determination. If insufficient information has been provided to the
7 carrier to make a decision, the carrier shall request any additional
8 information from the provider or facility within five calendar days
9 of submission of the nonelectronic prior authorization request.

10 (ii) For nonelectronic expedited prior authorization requests,
11 the carrier shall make a decision and notify the provider or facility
12 of the results of the decision within two calendar days of submission
13 of a nonelectronic prior authorization request by the provider or
14 facility that contains the necessary information to make a
15 determination. If insufficient information has been provided to the
16 carrier to make a decision, the carrier shall request any additional
17 information from the provider or facility within one calendar day of
18 submission of the nonelectronic prior authorization request.

19 (c) In any instance in which a carrier has determined that a
20 provider or facility has not provided sufficient information for
21 making a determination under (a) and (b) of this subsection, a
22 carrier may establish a specific reasonable time frame for submission
23 of the additional information. This time frame must be communicated
24 to the provider and enrollee with a carrier's request for additional
25 information.

26 (d) The carrier's prior authorization requirements must be
27 described in detail and written in easily understandable language.
28 The carrier shall make its most current prior authorization
29 requirements and restrictions, including the written clinical review
30 criteria, available to providers and facilities in an electronic
31 format upon request. The prior authorization requirements must be
32 based on peer-reviewed clinical review criteria. The clinical review
33 criteria must be evidence-based criteria and must accommodate new and
34 emerging information related to the appropriateness of clinical
35 criteria with respect to black and indigenous people, other people of
36 color, gender, and underserved populations. The clinical review
37 criteria must be evaluated and updated, if necessary, at least
38 annually.

39 ~~((2))~~ (e) When denying a prior authorization determination, the
40 carrier shall include the credentials, board certifications, and

1 areas of specialty expertise and training of the provider who had
2 clinical oversight over the determination in any notification sent to
3 the health plan enrollee and provider requesting or referring the
4 service.

5 (2)(a) Carriers maintain the ability to make adjustments to
6 policies and procedures that impact the applicability of their prior
7 authorization requirements. Except as provided in (b) of this
8 subsection, beginning August 1, 2025, these adjustments can only be
9 made quarterly and go into effect either January 1st, April 1st, July
10 1st, or October 1st of any given calendar year. Notification of
11 policy changes must be provided to all in-network providers at least
12 45 days prior to the quarterly update and must be available to
13 providers in a single location on the carrier's website. The
14 notification must be provided independent of other policy changes or
15 provider notification publications and be easily accessible in
16 electronic provider and enrollee portals.

17 (b) Adjustments to policies and procedures that impact the
18 applicability of prior authorization requirements to reflect federal
19 food and drug administration approvals, national comprehensive cancer
20 network guidelines, United States preventive services task force
21 guidelines, or state or national public health emergencies may be
22 made at any time and shall be posted on the website referenced in (a)
23 of this subsection. Notification of adjustments made under this
24 subsection must be provided to all in-network providers as soon as
25 possible.

26 (3)(a) Only a licensed physician or a licensed health
27 professional working within their scope of practice may deny a prior
28 authorization request based on medical necessity. The licensed
29 physician or licensed health professional shall evaluate the specific
30 clinical issues involved in the health care services requested by the
31 requesting provider by reviewing and considering the requesting
32 provider's recommendation, the enrollee's medical or other clinical
33 history, as applicable, and individual clinical circumstances. An
34 artificial intelligence tool shall not be the sole means used to
35 deny, delay, or modify health care services. Algorithms may be used
36 to process and approve prior authorization requests, but may not be
37 used without human review to deny care based on a determination of
38 medical necessity.

39 (b) A carrier that uses an artificial intelligence tool for the
40 purpose of prior authorization or prior authorization functions,

1 based in whole or in part on medical necessity, or that contracts
2 with or otherwise works through an entity that uses an artificial
3 intelligence tool for the purpose of prior authorization or prior
4 authorization functions, based in whole or in part on medical
5 necessity, shall ensure all of the following:

6 (i) The artificial intelligence tool bases its determination on
7 the following information, as applicable:

8 (A) An enrollee's medical or other clinical history, including
9 demographic data; and

10 (B) Individual clinical circumstances as presented by the
11 requesting provider;

12 (ii) The artificial intelligence tool does not base its
13 determination solely on a group data set;

14 (iii) The artificial intelligence tool's criteria and guidelines
15 comply with this chapter and applicable state and federal law;

16 (iv) The use of the artificial intelligence tool does not
17 discriminate, directly or indirectly, against an enrollee in
18 violation of state or federal law;

19 (v) The artificial intelligence tool is fairly and equitably
20 applied, including in accordance with any applicable regulations and
21 guidance issued by the federal department of health and human
22 services;

23 (vi) The policies and procedures for using the artificial
24 intelligence tool are open to audit by the office of the insurance
25 commissioner under chapter 48.37 RCW;

26 (vii) The artificial intelligence tool's performance, use, and
27 outcomes are periodically reviewed by the carrier to maximize
28 accuracy and reliability; and

29 (viii) Patient data is not used beyond its intended and stated
30 purpose, consistent with chapter 70.02 RCW and the federal health
31 insurance portability and accountability act of 1996, 42 U.S.C. Sec.
32 1320d et al., as applicable.

33 (4)(a) Each carrier shall build and maintain a prior
34 authorization application programming interface that automates the
35 process for in-network providers to determine whether a prior
36 authorization is required for health care services, identify prior
37 authorization information and documentation requirements, and
38 facilitate the exchange of prior authorization requests and
39 determinations from its electronic health records or practice
40 management system. The application programming interface must support

1 the exchange of prior authorization requests and determinations for
2 health care services beginning January 1, 2025, and must:

3 (i) Use health level 7 fast health care interoperability
4 resources in accordance with standards and provisions defined in 45
5 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

6 (ii) Automate the process to determine whether a prior
7 authorization is required for durable medical equipment or a health
8 care service;

9 (iii) Allow providers to query the carrier's prior authorization
10 documentation requirements;

11 (iv) Support an automated approach using nonproprietary open
12 workflows to compile and exchange the necessary data elements to
13 populate the prior authorization requirements that are compliant with
14 the federal health insurance portability and accountability act of
15 1996 or have an exception from the federal centers for medicare and
16 medicaid services; ~~((and))~~

17 (v) Indicate that a prior authorization denial or authorization
18 of a service less intensive than that included in the original
19 request is an adverse benefit determination and is subject to the
20 carrier's grievance and appeal process under RCW 48.43.535; and

21 (vi) Include the credentials, board certifications, and areas of
22 specialty expertise and training of the provider who had clinical
23 oversight over the determination in any notification sent to the
24 health plan enrollee and provider requesting or referring the
25 service.

26 (b) Each carrier shall establish and maintain an interoperable
27 electronic process or application programming interface that
28 automates the process for in-network providers to determine whether a
29 prior authorization is required for a covered prescription drug. The
30 application programming interface must support the exchange of prior
31 authorization requests and determinations for prescription drugs,
32 including information on covered alternative prescription drugs,
33 beginning January 1, 2027, and must:

34 (i) Allow providers to identify prior authorization information
35 and documentation requirements;

36 (ii) Facilitate the exchange of prior authorization requests and
37 determinations from its electronic health records or practice
38 management system, and may include the necessary data elements to
39 populate the prior authorization requirements that are compliant with
40 the federal health insurance portability and accountability act of

1 1996 or have an exception from the federal centers for medicare and
2 medicaid services; and

3 (iii) Indicate that a prior authorization denial or authorization
4 of a drug other than the one included in the original prior
5 authorization request is an adverse benefit determination and is
6 subject to the carrier's grievance and appeal process under RCW
7 48.43.535.

8 (c) If federal rules related to standards for using an
9 application programming interface to communicate prior authorization
10 status to providers are not finalized by the federal centers for
11 medicare and medicaid services by September 13, 2023, the
12 requirements of (a) of this subsection may not be enforced until
13 January 1, 2026.

14 (d)(i) If a carrier determines that it will not be able to
15 satisfy the requirements of (a) of this subsection by January 1,
16 2025, the carrier shall submit a narrative justification to the
17 commissioner on or before September 1, 2024, describing:

18 (A) The reasons that the carrier cannot reasonably satisfy the
19 requirements;

20 (B) The impact of noncompliance upon providers and enrollees;

21 (C) The current or proposed means of providing health information
22 to the providers; and

23 (D) A timeline and implementation plan to achieve compliance with
24 the requirements.

25 (ii) The commissioner may grant a one-year delay in enforcement
26 of the requirements of (a) of this subsection (~~((+2+))~~) (4) if the
27 commissioner determines that the carrier has made a good faith effort
28 to comply with the requirements.

29 (iii) This subsection (~~((+2+))~~) (4)(d) shall not apply if the delay
30 in enforcement in (c) of this subsection takes effect because the
31 federal centers for medicare and medicaid services did not finalize
32 the applicable regulations by September 13, 2023.

33 (e) By September 13, 2023, and at least every six months
34 thereafter until September 13, 2026, the commissioner shall provide
35 an update to the health care policy committees of the legislature on
36 the development of rules and implementation guidance from the federal
37 centers for medicare and medicaid services regarding the standards
38 for development of application programming interfaces and
39 interoperable electronic processes related to prior authorization
40 functions. The updates should include recommendations, as

1 appropriate, on whether the status of the federal rule development
2 aligns with the provisions of chapter 382, Laws of 2023. The
3 commissioner also shall report on any actions by the federal centers
4 for medicare and medicaid services to exercise enforcement discretion
5 related to the implementation and maintenance of an application
6 programming interface for prior authorization functions. The
7 commissioner shall consult with the health care authority, carriers,
8 providers, and consumers on the development of these updates and any
9 recommendations.

10 ~~((3))~~ (5) Nothing in this section applies to prior
11 authorization determinations made pursuant to RCW 48.43.761.

12 ~~((4))~~ (6) This section applies to prior authorization functions
13 carried out by health care benefit managers, as defined in RCW
14 48.200.020, under direct or indirect contract with a carrier.

15 (7) The commissioner may adopt any rules necessary to implement
16 this section.

17 (8) For the purposes of this section:

18 (a) "Artificial intelligence" means the use of machine learning
19 and related technologies that use data to train statistical models
20 for the purpose of enabling computer systems to perform tasks
21 normally associated with human intelligence or perception, such as
22 computer vision, speech or natural language processing, and content
23 generation. "Artificial intelligence" includes generative artificial
24 intelligence.

25 (b) "Expedited prior authorization request" means a request by a
26 provider or facility for approval of a health care service or
27 prescription drug where:

28 (i) The passage of time:

29 (A) Could seriously jeopardize the life or health of the
30 enrollee;

31 (B) Could seriously jeopardize the enrollee's ability to regain
32 maximum function; or

33 (C) In the opinion of a provider or facility with knowledge of
34 the enrollee's medical condition, would subject the enrollee to
35 severe pain that cannot be adequately managed without the health care
36 service or prescription drug that is the subject of the request; or

37 (ii) The enrollee is undergoing a current course of treatment
38 using a nonformulary drug.

1 ~~((b))~~ (c) "Generative artificial intelligence" means an
2 artificial intelligence system that generates novel data or content
3 based on a foundation model.

4 (d) "Machine learning" means the process by which artificial
5 intelligence is developed using data and algorithms to draw
6 inferences therefrom to automatically adapt or improve its accuracy
7 without explicit programming.

8 (e) "Standard prior authorization request" means a request by a
9 provider or facility for approval of a health care service or
10 prescription drug where the request is made in advance of the
11 enrollee obtaining a health care service or prescription drug that is
12 not required to be expedited.

13 **Sec. 3.** RCW 74.09.840 and 2023 c 382 s 3 are each amended to
14 read as follows:

15 (1) Beginning January 1, 2024, the authority shall require each
16 managed care organization to comply with the following standards
17 related to prior authorization for health care services and
18 prescription drugs:

19 (a) The managed care organization shall meet the following time
20 frames for prior authorization determinations and notifications to a
21 participating provider or facility that submits the prior
22 authorization request through an electronic prior authorization
23 process, as designated by each managed care organization:

24 (i) For electronic standard prior authorization requests, the
25 managed care organization shall make a decision and notify the
26 provider or facility of the results of the decision within three
27 calendar days, excluding holidays, of submission of an electronic
28 prior authorization request by the provider or facility that contains
29 the necessary information to make a determination. If insufficient
30 information has been provided to the managed care organization to
31 make a decision, the managed care organization shall request any
32 additional information from the provider or facility within one
33 calendar day of submission of the electronic prior authorization
34 request.

35 (ii) For electronic expedited prior authorization requests, the
36 managed care organization shall make a decision and notify the
37 provider or facility of the results of the decision within one
38 calendar day of submission of an electronic prior authorization
39 request by the provider or facility that contains the necessary

1 information to make a determination. If insufficient information has
2 been provided to the managed care organization to make a decision,
3 the managed care organization shall request any additional
4 information from the provider or facility within one calendar day of
5 submission of the electronic prior authorization request.

6 (b) The managed care organization shall meet the following time
7 frames for prior authorization determinations and notifications to a
8 participating provider or facility that submits the prior
9 authorization request through a process other than an electronic
10 prior authorization process described in subsection (~~((2))~~) (5) of
11 this section:

12 (i) For nonelectronic standard prior authorization requests, the
13 managed care organization shall make a decision and notify the
14 provider or facility of the results of the decision within five
15 calendar days of submission of a nonelectronic prior authorization
16 request by the provider or facility that contains the necessary
17 information to make a determination. If insufficient information has
18 been provided to the managed care organization to make a decision,
19 the managed care organization shall request any additional
20 information from the provider or facility within five calendar days
21 of submission of the nonelectronic prior authorization request.

22 (ii) For nonelectronic expedited prior authorization requests,
23 the managed care organization shall make a decision and notify the
24 provider or facility of the results of the decision within two
25 calendar days of submission of a nonelectronic prior authorization
26 request by the provider or facility that contains the necessary
27 information to make a determination. If insufficient information has
28 been provided to the managed care organization to make a decision,
29 the managed care organization shall request any additional
30 information from the provider or facility within one calendar day of
31 submission of the nonelectronic prior authorization request.

32 (c) In any instance in which a managed care organization has
33 determined that a provider or facility has not provided sufficient
34 information for making a determination under (a) and (b) of this
35 subsection, a managed care organization may establish a specific
36 reasonable time frame for submission of the additional information.
37 This time frame must be communicated to the provider and enrollee
38 with a managed care organization's request for additional
39 information.

1 (d) The prior authorization requirements of the managed care
2 organization must be described in detail and written in easily
3 understandable language. The managed care organization shall make its
4 most current prior authorization requirements and restrictions,
5 including the written clinical review criteria, available to
6 providers and facilities in an electronic format upon request. The
7 prior authorization requirements must be based on peer-reviewed
8 clinical review criteria. The clinical review criteria must be
9 evidence-based criteria and must accommodate new and emerging
10 information related to the appropriateness of clinical criteria with
11 respect to black and indigenous people, other people of color,
12 gender, and underserved populations. The clinical review criteria
13 must be evaluated and updated, if necessary, at least annually.

14 ~~((2))~~ (e) When denying a prior authorization determination, the
15 managed care organization shall include the credentials, board
16 certifications, and areas of specialty expertise and training of the
17 provider who had clinical oversight over the determination in any
18 notification sent to the managed care enrollee and provider
19 requesting or referring the service.

20 (2) (a) Managed care organizations maintain the ability to make
21 adjustments to policies and procedures that impact the applicability
22 of their prior authorization requirements. Except as provided in (b)
23 of this subsection, beginning August 1, 2025, these adjustments can
24 only be made quarterly and go into effect either January 1st, April
25 1st, July 1st, or October 1st of any given calendar year.
26 Notification of policy changes must be provided to all in-network
27 providers at least 45 days prior to the quarterly update and must be
28 available to providers in a single location on the managed care
29 organization's website. The notification must be provided independent
30 of other policy changes or provider notification publications and be
31 easily accessible in electronic provider and enrollee portals.

32 (b) Adjustments to policies and procedures that impact the
33 applicability of prior authorization requirements to reflect federal
34 food and drug administration approvals, national comprehensive cancer
35 network guidelines, United States preventive services task force
36 guidelines, or state or national public health emergencies may be
37 made at any time and shall be posted on the website referenced in (a)
38 of this subsection. Notification of adjustments made under this
39 subsection must be provided to all in-network providers as soon as
40 possible.

1 (3) (a) Only a licensed physician or a licensed health
2 professional working within their scope of practice may deny a prior
3 authorization request based on medical necessity. The licensed
4 physician or licensed health professional shall evaluate the specific
5 clinical issues involved in the health care services requested by the
6 requesting provider by reviewing and considering the requesting
7 provider's recommendation, the enrollee's medical or other clinical
8 history, as applicable, and individual clinical circumstances. An
9 artificial intelligence tool shall not be the sole means used to
10 deny, delay, or modify health care services. Algorithms may be used
11 to process and approve prior authorization requests, but may not be
12 used without human review to deny care based on a determination of
13 medical necessity.

14 (b) A managed care organization that uses an artificial
15 intelligence tool for the purpose of prior authorization or prior
16 authorization functions, based in whole or in part on medical
17 necessity, or that contracts with or otherwise works through an
18 entity that uses an artificial intelligence tool for the purpose of
19 prior authorization or prior authorization functions, based in whole
20 or in part on medical necessity, shall ensure all of the following:

21 (i) The artificial intelligence tool bases its determination on
22 the following information, as applicable:

23 (A) An enrollee's medical or other clinical history, including
24 demographic data; and

25 (B) Individual clinical circumstances as presented by the
26 requesting provider;

27 (ii) The artificial intelligence tool does not base its
28 determination solely on a group data set;

29 (iii) The artificial intelligence tool's criteria and guidelines
30 comply with this chapter and applicable state and federal law;

31 (iv) The use of the artificial intelligence tool does not
32 discriminate, directly or indirectly, against an enrollee in
33 violation of state or federal law;

34 (v) The artificial intelligence tool is fairly and equitably
35 applied, including in accordance with any applicable regulations and
36 guidance issued by the federal department of health and human
37 services;

38 (vi) The policies and procedures for using the artificial
39 intelligence tool are open to audit by the authority consistent with
40 RCW 74.09.200;

1 (vii) The artificial intelligence tool's performance, use, and
2 outcomes are periodically reviewed by the managed care organization
3 to maximize accuracy and reliability; and

4 (viii) Patient data is not used beyond its intended and stated
5 purpose, consistent with chapter 70.02 RCW and the federal health
6 insurance portability and accountability act of 1996, 42 U.S.C. Sec.
7 1320d et al., as applicable.

8 (4) By July 1, 2027, the authority shall publish a list of
9 treatments, prescription drugs, equipment, and services, along with
10 their applicable billing codes, that specifies under which
11 circumstances prior authorization is required, prohibited, or has
12 other uniform application across the medical assistance program under
13 this chapter. The authority must consider applicable state and
14 federal laws when deciding which services are not subject to prior
15 authorization. The authority shall focus on existing prior
16 authorization requirements and treatments, prescription drugs,
17 equipment, and services that are treated inconsistently in the
18 medical assistance program. The authority shall update the list at
19 least annually and provide notice and an opportunity for public
20 comment prior to finalizing the list. Nothing in this subsection
21 alters existing obligations of the authority and managed care
22 organizations to ensure enrollee access to treatments, prescription
23 drugs, equipment, and services that are not included in the list.
24 Nothing in this section prohibits the authority and managed care
25 organizations from applying other utilization management strategies,
26 consistent with state and federal law, for services for which prior
27 authorization is not required.

28 (5)(a) Each managed care organization shall build and maintain a
29 prior authorization application programming interface that automates
30 the process for in-network providers to determine whether a prior
31 authorization is required for health care services, identify prior
32 authorization information and documentation requirements, and
33 facilitate the exchange of prior authorization requests and
34 determinations from its electronic health records or practice
35 management system. The application programming interface must support
36 the exchange of prior authorization requests and determinations for
37 health care services beginning January 1, 2025, and must:

38 (i) Use health level 7 fast health care interoperability
39 resources in accordance with standards and provisions defined in 45
40 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

1 (ii) Automate the process to determine whether a prior
2 authorization is required for durable medical equipment or a health
3 care service;

4 (iii) Allow providers to query the managed care organization's
5 prior authorization documentation requirements;

6 (iv) Support an automated approach using nonproprietary open
7 workflows to compile and exchange the necessary data elements to
8 populate the prior authorization requirements that are compliant with
9 the federal health insurance portability and accountability act of
10 1996 or have an exception from the federal centers for medicare and
11 medicaid services; and

12 (v) Indicate that a prior authorization denial or authorization
13 of a service less intensive than that included in the original
14 request is an adverse benefit determination and is subject to the
15 managed care organization's grievance and appeal process under RCW
16 48.43.535.

17 (b) Each managed care organization shall establish and maintain
18 an interoperable electronic process or application programming
19 interface that automates the process for in-network providers to
20 determine whether a prior authorization is required for a covered
21 prescription drug. The application programming interface must support
22 the exchange of prior authorization requests and determinations for
23 prescription drugs, including information on covered alternative
24 prescription drugs, beginning January 1, 2027, and must:

25 (i) Allow providers to identify prior authorization information
26 and documentation requirements;

27 (ii) Facilitate the exchange of prior authorization requests and
28 determinations from its electronic health records or practice
29 management system, and may include the necessary data elements to
30 populate the prior authorization requirements that are compliant with
31 the federal health insurance portability and accountability act of
32 1996 or have an exception from the federal centers for medicare and
33 medicaid services; ~~((and))~~

34 (iii) Indicate that a prior authorization denial or authorization
35 of a drug other than the one included in the original prior
36 authorization request is an adverse benefit determination and is
37 subject to the managed care organization's grievance and appeal
38 process under RCW 48.43.535; and

39 (iv) Include the credentials, board certifications, and areas of
40 specialty expertise and training of the provider who had clinical

1 oversight over the determination in any notification sent to the
2 managed care enrollee and provider requesting or referring the
3 service.

4 (c) If federal rules related to standards for using an
5 application programming interface to communicate prior authorization
6 status to providers are not finalized by September 13, 2023, the
7 requirements of (a) of this subsection may not be enforced until
8 January 1, 2026.

9 (d) (i) If a managed care organization determines that it will not
10 be able to satisfy the requirements of (a) of this subsection by
11 January 1, 2025, the managed care organization shall submit a
12 narrative justification to the authority on or before September 1,
13 2024, describing:

14 (A) The reasons that the managed care organization cannot
15 reasonably satisfy the requirements;

16 (B) The impact of noncompliance upon providers and enrollees;

17 (C) The current or proposed means of providing health information
18 to the providers; and

19 (D) A timeline and implementation plan to achieve compliance with
20 the requirements.

21 (ii) The authority may grant a one-year delay in enforcement of
22 the requirements of (a) of this subsection (~~((2))~~) (5) if the
23 authority determines that the managed care organization has made a
24 good faith effort to comply with the requirements.

25 (iii) This subsection (~~((2))~~) (5) (d) shall not apply if the delay
26 in enforcement in (c) of this subsection takes effect because the
27 federal centers for medicare and medicaid services did not finalize
28 the applicable regulations by September 13, 2023.

29 (~~((3))~~) (6) This section applies to prior authorization functions
30 carried out by health care benefit managers, as defined in RCW
31 48.200.020, under direct or indirect contract with a carrier.

32 (7) The authority may adopt any rules necessary to implement this
33 section.

34 (8) Nothing in this section applies to prior authorization
35 determinations made pursuant to RCW 71.24.618 or 74.09.490.

36 (~~((4))~~) (9) For the purposes of this section:

37 (a) "Artificial intelligence" means the use of machine learning
38 and related technologies that use data to train statistical models
39 for the purpose of enabling computer systems to perform tasks
40 normally associated with human intelligence or perception, such as

1 computer vision, speech or natural language processing, and content
2 generation. "Artificial intelligence" includes generative artificial
3 intelligence.

4 (b) "Expedited prior authorization request" means a request by a
5 provider or facility for approval of a health care service or
6 prescription drug where:

7 (i) The passage of time:

8 (A) Could seriously jeopardize the life or health of the
9 enrollee;

10 (B) Could seriously jeopardize the enrollee's ability to regain
11 maximum function; or

12 (C) In the opinion of a provider or facility with knowledge of
13 the enrollee's medical condition, would subject the enrollee to
14 severe pain that cannot be adequately managed without the health care
15 service or prescription drug that is the subject of the request; or

16 (ii) The enrollee is undergoing a current course of treatment
17 using a nonformulary drug.

18 (~~(b)~~) (c) "Generative artificial intelligence" means an
19 artificial intelligence system that generates novel data or content
20 based on a foundation model.

21 (d) "Machine learning" means the process by which artificial
22 intelligence is developed using data and algorithms to draw
23 inferences therefrom to automatically adapt or improve its accuracy
24 without explicit programming.

25 (e) "Standard prior authorization request" means a request by a
26 provider or facility for approval of a health care service or
27 prescription drug where the request is made in advance of the
28 enrollee obtaining a health care service or prescription drug that is
29 not required to be expedited.

30 **Sec. 4.** RCW 41.05.845 and 2023 c 382 s 2 are each amended to
31 read as follows:

32 (1) A health plan offered to public employees, retirees, and
33 their covered dependents under this chapter issued or renewed on or
34 after January 1, 2024, shall comply with the following standards
35 related to prior authorization for health care services and
36 prescription drugs:

37 (a) The health plan shall meet the following time frames for
38 prior authorization determinations and notifications to a
39 participating provider or facility that submits the prior

1 authorization request through an electronic prior authorization
2 process:

3 (i) For electronic standard prior authorization requests, the
4 health plan shall make a decision and notify the provider or facility
5 of the results of the decision within three calendar days, excluding
6 holidays, of submission of an electronic prior authorization request
7 by the provider or facility that contains the necessary information
8 to make a determination. If insufficient information has been
9 provided to the health plan to make a decision, the health plan shall
10 request any additional information from the provider or facility
11 within one calendar day of submission of the electronic prior
12 authorization request.

13 (ii) For electronic expedited prior authorization requests, the
14 health plan shall make a decision and notify the provider or facility
15 of the results of the decision within one calendar day of submission
16 of an electronic prior authorization request by the provider or
17 facility that contains the necessary information to make a
18 determination. If insufficient information has been provided to the
19 health plan to make a decision, the health plan shall request any
20 additional information from the provider or facility within one
21 calendar day of submission of the electronic prior authorization
22 request.

23 (b) The health plan shall meet the following time frames for
24 prior authorization determinations and notifications to a
25 participating provider or facility that submits the prior
26 authorization request through a process other than an electronic
27 prior authorization process described in subsection (~~((2))~~) (4) of
28 this section:

29 (i) For nonelectronic standard prior authorization requests, the
30 health plan shall make a decision and notify the provider or facility
31 of the results of the decision within five calendar days of
32 submission of a nonelectronic prior authorization request by the
33 provider or facility that contains the necessary information to make
34 a determination. If insufficient information has been provided to the
35 health plan to make a decision, the health plan shall request any
36 additional information from the provider or facility within five
37 calendar days of submission of the nonelectronic prior authorization
38 request.

39 (ii) For nonelectronic expedited prior authorization requests,
40 the health plan shall make a decision and notify the provider or

1 facility of the results of the decision within two calendar days of
2 submission of a nonelectronic prior authorization request by the
3 provider or facility that contains the necessary information to make
4 a determination. If insufficient information has been provided to the
5 health plan to make a decision, the health plan shall request any
6 additional information from the provider or facility within one
7 calendar day of submission of the nonelectronic prior authorization
8 request.

9 (c) In any instance in which the health plan has determined that
10 a provider or facility has not provided sufficient information for
11 making a determination under (a) and (b) of this subsection, the
12 health plan may establish a specific reasonable time frame for
13 submission of the additional information. This time frame must be
14 communicated to the provider and enrollee with the health plan's
15 request for additional information.

16 (d) The prior authorization requirements of the health plan must
17 be described in detail and written in easily understandable language.
18 The health plan shall make its most current prior authorization
19 requirements and restrictions, including the written clinical review
20 criteria, available to providers and facilities in an electronic
21 format upon request. The prior authorization requirements must be
22 based on peer-reviewed clinical review criteria. The clinical review
23 criteria must be evidence-based criteria and must accommodate new and
24 emerging information related to the appropriateness of clinical
25 criteria with respect to black and indigenous people, other people of
26 color, gender, and underserved populations. The clinical review
27 criteria must be evaluated and updated, if necessary, at least
28 annually.

29 ~~((2))~~ (e) When denying a prior authorization determination, the
30 health plan shall include the credentials, board certifications, and
31 areas of specialty expertise and training of the provider who had
32 clinical oversight over the determination in any notification sent to
33 the health plan enrollee and provider requesting or referring the
34 service.

35 (2)(a) Health plans maintain the ability to make adjustments to
36 policies and procedures that impact the applicability of their prior
37 authorization requirements. Except as provided in (b) of this
38 subsection, beginning August 1, 2025, these adjustments can only be
39 made quarterly and go into effect either January 1st, April 1st, July
40 1st, or October 1st of any given calendar year. Notification of

1 policy changes must be provided to all in-network providers at least
2 45 days prior to the quarterly update and must be available to
3 providers in a single location on the health plan's website. The
4 notification must be provided independent of other policy changes or
5 provider notification publications and be easily accessible in
6 electronic provider and enrollee portals.

7 (b) Adjustments to policies and procedures that impact the
8 applicability of prior authorization requirements to reflect federal
9 food and drug administration approvals, national comprehensive cancer
10 network guidelines, United States preventive services task force
11 guidelines, or state or national public health emergencies may be
12 made at any time and shall be posted on the website referenced in (a)
13 of this subsection. Notification of adjustments made under this
14 subsection must be provided to all in-network providers as soon as
15 possible.

16 (3) (a) Only a licensed physician or a licensed health
17 professional working within their scope of practice may deny a prior
18 authorization request based on medical necessity. The licensed
19 physician or licensed health professional shall evaluate the specific
20 clinical issues involved in the health care services requested by the
21 requesting provider by reviewing and considering the requesting
22 provider's recommendation, the enrollee's medical or other clinical
23 history, as applicable, and individual clinical circumstances. An
24 artificial intelligence tool shall not be the sole means used to
25 deny, delay, or modify health care services. Algorithms may be used
26 to process and approve prior authorization requests, but may not be
27 used without human review to deny care based on a determination of
28 medical necessity.

29 (b) A health plan that uses an artificial intelligence tool for
30 the purpose of prior authorization or prior authorization functions,
31 based in whole or in part on medical necessity, or that contracts
32 with or otherwise works through an entity that uses an artificial
33 intelligence tool for the purpose of prior authorization or prior
34 authorization functions, based in whole or in part on medical
35 necessity, shall ensure all of the following:

36 (i) The artificial intelligence tool bases its determination on
37 the following information, as applicable:

38 (A) An enrollee's medical or other clinical history, including
39 demographic data; and

1 (B) Individual clinical circumstances as presented by the
2 requesting provider;

3 (ii) The artificial intelligence tool does not base its
4 determination solely on a group data set;

5 (iii) The artificial intelligence tool's criteria and guidelines
6 comply with this chapter and applicable state and federal law;

7 (iv) The use of the artificial intelligence tool does not
8 discriminate, directly or indirectly, against an enrollee in
9 violation of state or federal law;

10 (v) The artificial intelligence tool is fairly and equitably
11 applied, including in accordance with any applicable regulations and
12 guidance issued by the federal department of health and human
13 services;

14 (vi) The policies and procedures for using the artificial
15 intelligence tool is open to audit by the office of the insurance
16 commissioner;

17 (vii) The artificial intelligence tool's performance, use, and
18 outcomes are periodically reviewed by the health plan to maximize
19 accuracy and reliability; and

20 (viii) Patient data is not used beyond its intended and stated
21 purpose, consistent with chapter 70.02 RCW and the federal health
22 insurance portability and accountability act of 1996, U.S.C. Sec.
23 1320d et al., as applicable.

24 (4)(a) Each health plan offered to public employees, retirees,
25 and their covered dependents under this chapter shall build and
26 maintain a prior authorization application programming interface that
27 automates the process for in-network providers to determine whether a
28 prior authorization is required for health care services, identify
29 prior authorization information and documentation requirements, and
30 facilitate the exchange of prior authorization requests and
31 determinations from its electronic health records or practice
32 management system. The application programming interface must support
33 the exchange of prior authorization requests and determinations for
34 health care services beginning January 1, 2025, and must:

35 (i) Use health level 7 fast health care interoperability
36 resources in accordance with standards and provisions defined in 45
37 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

38 (ii) Automate the process to determine whether a prior
39 authorization is required for durable medical equipment or a health
40 care service;

1 (iii) Allow providers to query the health plan's prior
2 authorization documentation requirements;

3 (iv) Support an automated approach using nonproprietary open
4 workflows to compile and exchange the necessary data elements to
5 populate the prior authorization requirements that are compliant with
6 the federal health insurance portability and accountability act of
7 1996 or have an exception from the federal centers for medicare and
8 medicaid services; ~~((and))~~

9 (v) Indicate that a prior authorization denial or authorization
10 of a service less intensive than that included in the original
11 request is an adverse benefit determination and is subject to the
12 health plan's grievance and appeal process under RCW 48.43.535; and

13 (vi) Include the credentials, board certifications, and areas of
14 specialty expertise and training of the provider who had clinical
15 oversight over the determination in any notification sent to the
16 health plan enrollee and provider requesting or referring the
17 service.

18 (b) Each health plan offered to public employees, retirees, and
19 their covered dependents under this chapter shall establish and
20 maintain an interoperable electronic process or application
21 programming interface that automates the process for in-network
22 providers to determine whether a prior authorization is required for
23 a covered prescription drug. The application programming interface
24 must support the exchange of prior authorization requests and
25 determinations for prescription drugs, including information on
26 covered alternative prescription drugs, beginning January 1, 2027,
27 and must:

28 (i) Allow providers to identify prior authorization information
29 and documentation requirements;

30 (ii) Facilitate the exchange of prior authorization requests and
31 determinations from its electronic health records or practice
32 management system, and may include the necessary data elements to
33 populate the prior authorization requirements that are compliant with
34 the federal health insurance portability and accountability act of
35 1996 or have an exception from the federal centers for medicare and
36 medicaid services; and

37 (iii) Indicate that a prior authorization denial or authorization
38 of a drug other than the one included in the original prior
39 authorization request is an adverse benefit determination and is

1 subject to the health plan's grievance and appeal process under RCW
2 48.43.535.

3 (c) If federal rules related to standards for using an
4 application programming interface to communicate prior authorization
5 status to providers are not finalized by the federal centers for
6 medicare and medicaid services by September 13, 2023, the
7 requirements of (a) of this subsection may not be enforced until
8 January 1, 2026.

9 (d)(i) If the health plan determines that it will not be able to
10 satisfy the requirements of (a) of this subsection by January 1,
11 2025, the health plan shall submit a narrative justification to the
12 authority on or before September 1, 2024, describing:

13 (A) The reasons that the health plan cannot reasonably satisfy
14 the requirements;

15 (B) The impact of noncompliance upon providers and enrollees;

16 (C) The current or proposed means of providing health information
17 to the providers; and

18 (D) A timeline and implementation plan to achieve compliance with
19 the requirements.

20 (ii) The authority may grant a one-year delay in enforcement of
21 the requirements of (a) of this subsection (~~((2))~~) (4) if the
22 authority determines that the health plan has made a good faith
23 effort to comply with the requirements.

24 (iii) This subsection (~~((2))~~) (4)(d) shall not apply if the delay
25 in enforcement in (c) of this subsection takes effect because the
26 federal centers for medicare and medicaid services did not finalize
27 the applicable regulations by September 13, 2023.

28 (~~((3))~~) (5) Nothing in this section applies to prior
29 authorization determinations made pursuant to RCW 41.05.526.

30 (~~((4))~~) (6) This section applies to prior authorization functions
31 carried out by health care benefit managers, as defined in RCW
32 48.200.020, under direct or indirect contract with a carrier.

33 (7) The commissioner may adopt any rules necessary to implement
34 this section.

35 (8) For the purposes of this section:

36 (a) "Artificial intelligence" means the use of machine learning
37 and related technologies that use data to train statistical models
38 for the purpose of enabling computer systems to perform tasks
39 normally associated with human intelligence or perception, such as
40 computer vision, speech or natural language processing, and content

1 generation. "Artificial intelligence" includes generative artificial
2 intelligence.

3 (b) "Expedited prior authorization request" means a request by a
4 provider or facility for approval of a health care service or
5 prescription drug where:

6 (i) The passage of time:

7 (A) Could seriously jeopardize the life or health of the
8 enrollee;

9 (B) Could seriously jeopardize the enrollee's ability to regain
10 maximum function; or

11 (C) In the opinion of a provider or facility with knowledge of
12 the enrollee's medical condition, would subject the enrollee to
13 severe pain that cannot be adequately managed without the health care
14 service or prescription drug that is the subject of the request; or

15 (ii) The enrollee is undergoing a current course of treatment
16 using a nonformulary drug.

17 (~~(b)~~) (c) "Generative artificial intelligence" means an
18 artificial intelligence system that generates novel data or content
19 based on a foundation model.

20 (d) "Machine learning" means the process by which artificial
21 intelligence is developed using data and algorithms to draw
22 inferences therefrom to automatically adapt or improve its accuracy
23 without explicit programming.

24 (e) "Standard prior authorization request" means a request by a
25 provider or facility for approval of a health care service or
26 prescription drug where the request is made in advance of the
27 enrollee obtaining a health care service that is not required to be
28 expedited.

29 (~~(5)~~) (9) This section shall not apply to coverage provided
30 under the medicare part C or part D programs set forth in Title XVIII
31 of the social security act of 1965, as amended.

32 **Sec. 5.** RCW 48.43.525 and 2000 c 5 s 9 are each amended to read
33 as follows:

34 (1) A health carrier that offers a health plan shall not
35 retrospectively deny coverage or retrospectively modify to a service
36 less intensive than that included in the original request for
37 emergency and nonemergency care that had prior authorization,
38 including for medical necessity, under the plan's written policies at
39 the time the care was rendered, unless:

1 (a) The prior authorization was based upon a material
2 misrepresentation by the provider, facility, or covered person; or

3 (b) The underlying health plan coverage is lawfully rescinded,
4 canceled, or terminated retrospectively through the date of service.

5 (2) Retrospective denials of services with prior authorization or
6 retrospective modification to less intensive services due to a change
7 in the carrier's determination of medical necessity are prohibited,
8 shall not be considered adverse benefit determinations, and will not
9 be required to follow the standard appeals processes in RCW 48.43.530
10 or any carrier policies related to their own grievance and appeals
11 process. If an enrollee or the provider requesting the original
12 authorization demonstrates the authorization was valid per the plan's
13 written policies, then the carrier will deem the authorization
14 approved and payable. Interest will be assessed on the associated
15 claim submitted by the provider at the rate of one percent per month,
16 retroactive to the original date of the authorization request.

17 (3) The commissioner shall adopt, in rule, standards for this
18 section after considering relevant standards adopted by national
19 managed care accreditation organizations and state agencies that
20 purchase managed health care services.

21 **Sec. 6.** RCW 48.43.0161 and 2023 c 382 s 4 are each amended to
22 read as follows:

23 (1) By ~~((October 1, 2020,))~~ January 1, 2026, and annually
24 thereafter, for individual and group health plans issued by a carrier
25 that has written at least one percent of the total accident and
26 health insurance premiums written by all companies authorized to
27 offer accident and health insurance in Washington in the most
28 recently available year, the carrier shall report to the commissioner
29 the following aggregated and deidentified data related to the
30 carrier's prior authorization practices and experience for the prior
31 plan year:

32 (a) The total number of prior authorization requests, approvals,
33 and denials. The carrier must report these totals separately for
34 approvals or denials made by the carrier directly and for approvals
35 or denials made by a health care benefit manager as defined in RCW
36 48.200.020 that is delegated to make prior authorization
37 determinations, either directly or indirectly, on behalf of the
38 carrier. In the report, carriers must also indicate:

1 (i) The percentage of total denials that were aided by artificial
2 intelligence tools; and

3 (ii) The percent of prior authorization determinations made after
4 the standard and expedited authorization request turnaround times
5 stated in RCW 48.43.830;

6 (b) Lists of the 10 inpatient medical or surgical codes:

7 (i) With the highest total number of prior authorization requests
8 during the previous plan year, including the total number of prior
9 authorization requests for each code and the percent of approved
10 requests for each code;

11 (ii) With the highest percentage of approved prior authorization
12 requests during the previous plan year, including the total number of
13 prior authorization requests for each code and the percent of
14 approved requests for each code; and

15 (iii) With the highest percentage of prior authorization requests
16 that were initially denied and then subsequently approved on appeal,
17 including the total number of prior authorization requests for each
18 code and the percent of requests that were initially denied and then
19 subsequently approved for each code;

20 ~~((b))~~ (c) Lists of the 10 outpatient medical or surgical codes:

21 (i) With the highest total number of prior authorization requests
22 during the previous plan year, including the total number of prior
23 authorization requests for each code and the percent of approved
24 requests for each code;

25 (ii) With the highest percentage of approved prior authorization
26 requests during the previous plan year, including the total number of
27 prior authorization requests for each code and the percent of
28 approved requests for each code; and

29 (iii) With the highest percentage of prior authorization requests
30 that were initially denied and then subsequently approved on appeal,
31 including the total number of prior authorization requests for each
32 code and the percent of requests that were initially denied and then
33 subsequently approved for each code;

34 ~~((e))~~ (d) Lists of the 10 inpatient mental health and substance
35 use disorder service codes:

36 (i) With the highest total number of prior authorization requests
37 during the previous plan year, including the total number of prior
38 authorization requests for each code and the percent of approved
39 requests for each code;

1 (ii) With the highest percentage of approved prior authorization
2 requests during the previous plan year, including the total number of
3 prior authorization requests for each code and the percent of
4 approved requests for each code; and

5 (iii) With the highest percentage of prior authorization requests
6 that were initially denied and then subsequently approved on appeal,
7 including the total number of prior authorization requests for each
8 code and the percent of requests that were initially denied and then
9 subsequently approved for each code;

10 ~~((d))~~ (e) Lists of the 10 outpatient mental health and
11 substance use disorder service codes:

12 (i) With the highest total number of prior authorization requests
13 during the previous plan year, including the total number of prior
14 authorization requests for each code and the percent of approved
15 requests for each code;

16 (ii) With the highest percentage of approved prior authorization
17 requests during the previous plan year, including the total number of
18 prior authorization requests for each code and the percent of
19 approved requests for each code; and

20 (iii) With the highest percentage of prior authorization requests
21 that were initially denied and then subsequently approved on appeal,
22 including the total number of prior authorization requests for each
23 code and the percent of requests that were initially denied and then
24 subsequently approved;

25 ~~((e))~~ (f) Lists of the 10 durable medical equipment codes:

26 (i) With the highest total number of prior authorization requests
27 during the previous plan year, including the total number of prior
28 authorization requests for each code and the percent of approved
29 requests for each code;

30 (ii) With the highest percentage of approved prior authorization
31 requests during the previous plan year, including the total number of
32 prior authorization requests for each code and the percent of
33 approved requests for each code; and

34 (iii) With the highest percentage of prior authorization requests
35 that were initially denied and then subsequently approved on appeal,
36 including the total number of prior authorization requests for each
37 code and the percent of requests that were initially denied and then
38 subsequently approved for each code;

39 ~~((f))~~ (g) Lists of the 10 diabetes supplies and equipment
40 codes:

1 (i) With the highest total number of prior authorization requests
2 during the previous plan year, including the total number of prior
3 authorization requests for each code and the percent of approved
4 requests for each code;

5 (ii) With the highest percentage of approved prior authorization
6 requests during the previous plan year, including the total number of
7 prior authorization requests for each code and the percent of
8 approved requests for each code; and

9 (iii) With the highest percentage of prior authorization requests
10 that were initially denied and then subsequently approved on appeal,
11 including the total number of prior authorization requests for each
12 code and the percent of requests that were initially denied and then
13 subsequently approved for each code;

14 ~~((g))~~ (h) Lists of the 10 prescription drugs:

15 (i) With the highest total number of prior authorization requests
16 during the previous plan year, including the total number of prior
17 authorization requests for each prescription drug and the percent of
18 approved requests for each prescription drug;

19 (ii) With the highest percentage of approved prior authorization
20 requests during the previous plan year, including the total number of
21 prior authorization requests for each prescription drug and the
22 percent of approved requests for each prescription drug; and

23 (iii) With the highest percentage of prior authorization requests
24 that were initially denied and then subsequently approved on appeal,
25 including the total number of prior authorization requests for each
26 prescription drug and the percent of requests that were initially
27 denied and then subsequently approved for each prescription drug; and

28 ~~((h))~~ (i) The average determination response time in hours for
29 prior authorization requests to the carrier in total reported under
30 (a) of this subsection and with respect to each code reported under
31 ~~((a))~~ (b) through ~~((f))~~ (h) of this subsection for each of the
32 following categories of prior authorization:

33 (i) Expedited decisions;

34 (ii) Standard decisions; and

35 (iii) Extenuating circumstances decisions.

36 (2) (a) By January 1, 2021, and annually thereafter, the
37 commissioner shall aggregate and deidentify the data collected under
38 subsection (1) of this section into a standard report and may not
39 identify the name of the carrier that submitted the data. The
40 commissioner must make the report available to interested parties.

1 (b) The report must contain trend data for total authorization
2 requests, approvals, and denials by plan and health care benefit
3 managers.

4 (3) The commissioner may request additional information from
5 carriers reporting data under this section.

6 (4) The commissioner may adopt rules to implement this section.
7 In adopting rules, the commissioner must consult stakeholders
8 including carriers, health care practitioners, health care
9 facilities, and patients.

10 (5) For the purpose of this section, "prior authorization" means
11 a mandatory process that a carrier or its designated or contracted
12 representative requires a provider or facility to follow before a
13 service is delivered, to determine if a service is a benefit and
14 meets the requirements for medical necessity, clinical
15 appropriateness, level of care, or effectiveness in relation to the
16 applicable plan, including any term used by a carrier or its
17 designated or contracted representative to describe this process.

--- END ---