WAC 284-43A-010 Definitions. The definitions in this section apply throughout the chapter unless the context clearly requires otherwise.

(1) "Adverse benefit determination" has the same meaning as defined in RCW 48.43.005 and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination;

(e) A carrier's denial of an application for coverage; or

(f) Any adverse determination made by a carrier under RCW 48.49.020, 48.49.030, or sections 2799A-1 or 2799A-2 of the Public Health Service Act (42 U.S.C. Sec. 300gg-111 or 300gg-112) and federal regulations implementing those provisions of P.L. 116-260. Examples of such determinations include, but are not limited to:

(i) Calculation of enrollee cost-sharing;

(ii) Application of consumer cost-sharing to an enrollee's deductible and maximum out-of-pocket; and

(iii) Determination of whether a claim is subject to the Balance Billing Protection Act.

(2) "Appellant" means an applicant or a person covered as an enrollee, subscriber, policyholder, participant, or beneficiary of an individual or group health plan, and when designated, their representative, as defined in WAC 284-43-3010. Consistent with the requirements of WAC 284-43-3170, providers seeking expedited review of an adverse benefit determination on behalf of an appellant may act as the appellant's representative even if the appellant has not formally notified the health plan or carrier of the designation.

(3) "Applicant" means a person or entity seeking to become a Washington certified independent review organization (IRO).

(4) "Attending provider" includes "treating provider" or "ordering provider" as used in WAC 284-43-4040 and 284-43-4060.

(5) "Carrier" or "health carrier" has the same meaning in this chapter as in WAC 284-43-0160(14).

(6) "Case" means a dispute relating to a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for health care service for an enrollee, which has been referred to a specific IRO by the insurance commissioner under RCW 48.43.535.

(7) "Clinical peer" means a physician or other health professional who holds an unrestricted license or certification and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category, as the attending provider. In a profession that has organized, board-certified specialties, a clinical peer generally will be in the same formal specialty.

(8) "Clinical reviewer" means a medical reviewer, as defined in this section.

(9) "Conflict of interest" means violation of any provision of WAC 284-43A-050 including, but not limited to, material familial, professional and financial affiliations.

(10) "Contract specialist" means a reviewer who deals with interpretation of health plan coverage provisions. If a clinical reviewer is also interpreting health plan coverage and contract provisions, that reviewer shall have the qualifications required of a contract specialist and clinical reviewer.

(11) "Commissioner" means the Washington state insurance com-missioner.

(12) "Enrollee" or "covered person" means an individual covered by a health plan including a subscriber, a policyholder, or beneficiary of a group plan, as defined in WAC 284-43-0160(5); means an "appellant" as defined in WAC 284-43-3010; and also means a person lawfully acting on behalf of the enrollee including, but not limited to, a parent or guardian.

(13) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(14) "Health care provider" or "provider" as used in WAC 284-43-0160 (13)(a) and (b), means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(15) "Independent review" means the process of review and determination of a case referred to an IRO under RCW 48.43.535.

(16) "Independent review organization" or "IRO" means an entity certified by the commissioner under this chapter.

(17) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(18) "Material professional affiliation" includes, but is not limited to, any provider-patient relationship, any partnership or employment relationship, or a shareholder or similar ownership interest in a professional corporation.

(19) "Material financial affiliation" means any financial interest including employment, contract or consultation which generates more than five percent of total annual revenue or total annual income of an IRO or an individual director, officer, executive or reviewer of the IRO. This includes a consulting relationship with a manufacturer regarding technology or research support for a specific product.

(20) "Medical reviewer" means a physician or other health care provider who is assigned to an external review case by a certified IRO, consistent with this chapter.

(21) "Medical, scientific, and cost-effectiveness evidence" means published evidence on results of clinical practice of any health profession which complies with one or more of the following requirements:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical and mental health journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

(c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;

(d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Healthcare Research and Quality, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services;

(f) Clinical practice guidelines that meet Institute of Medicine criteria; or

(g) In conjunction with other evidence, peer-reviewed abstracts accepted for presentation at major scientific or clinical meetings.

(22) "Referral" means receipt by an IRO of notification from the insurance commissioner or designee that a case has been assigned to that IRO under provisions of RCW 48.43.535.

(23) "Reviewer" or "expert reviewer" means a clinical reviewer or a contract specialist, as defined in this section.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43A-010, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.02.060, 48.43.535, and 48.43.537. WSR 16-23-168 (Matter No. R 2016-17), § 284-43A-010, filed 11/23/16, effective 1/1/17.]