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OFFICE OF THE
INSURANCE COMMISSIONER
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Technical Assistance Advisory (TAA) 2021-04[1]

[1] This advisory is an interpretive policy statement released to advise the public of the office of the insurance commissioner's (OIC) current opinions, approaches, and likely courses of action. It is advisory only. RCW 34.05.230(1).

The purpose of this TAA is to summarize current law and to provide guidance to health carriers. Specifically, this TAA is intended to assist health carriers as they work with substance use disorder treatment providers in complying with RCW 48.43.761.

Background: OIC has been working with the Washington state health care authority (HCA) to implement ESHB 2642,[2] which applies to health plans issued or renewed on or after January 1, 2021. RCW 48.43.761 addresses coverage of an initial period of substance use disorder treatment in withdrawal management services or an inpatient or residential treatment facility. Several questions have been raised regarding the applicability of RCW 48.43.761 to voluntary prior authorization for planned admissions. OIC has worked with HCA to develop consistent guidance to carriers, PEBB/SEBB contractors and medicaid managed care organizations (MCOs).

[2] Chapter 345, Laws of 2020; codified at RCW 48.43.761.

Interpretation of RCW 48.43.761: RCW 48.43.761 provides that a health plan may not require an enrollee to obtain prior authorization for an initial period of three days of withdrawal management services or two business days, excluding weekends and holidays, of inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037. Once this period has elapsed, utilization review can be conducted consistent with the provisions of RCW 48.43.761(2).

RCW 48.43.761 does not explicitly address those situations in which an enrollee and their substance use disorder treatment provider may seek voluntary prior authorization for an admission to provide greater certainty of coverage for a planned or scheduled admission to treatment, or to seek an initial authorization of coverage for a period greater than the two or three day period provided for in RCW 48.43.761.

OIC interprets RCW 48.43.761 to allow carriers to engage in prior authorization for inpatient or residential substance use disorder treatment if the prior authorization is voluntary and sought by the enrollee or their substance use disorder treatment provider prior to admission. However, RCW 48.43.761 does not require that carriers offer such an option to obtain a voluntary prior authorization.

Even when using a voluntary prior authorization process, carriers must still comply with all requirements of RCW 48.43.761 that are applicable in the voluntary prior authorization context.

- The minimum time frames established in RCW 48.43.761 (2)(a)(i) and (ii) apply to admissions that result from approval of a voluntary prior authorization request. A voluntary prior authorization must address the period subsequent to the two day period required in RCW 48.43.761 (2)(a)(i).

For withdrawal management services, a voluntary prior authorization must address the period subsequent to the three day period required in RCW 48.43.761 (2)(a)(ii).

For example, a voluntary prior authorization for five days of residential substance use disorder treatment would address five days after the initial two business days; a total of seven days of treatment would be paid for by the plan. The clinical material provided by the referring provider would need to support medical necessity for the level of care being requested for the five days of care being pre-authorized.[3]

3 In the event a voluntary prior authorization request is denied, and the client's condition thereafter changes to meet American Society of Addiction Medicine (ASAM) criteria for admission, a provider may admit a client based upon their assessment of medical necessity. RCW 48.43.761.

- For admissions under a voluntary prior authorization request, including an initial assessment and initial treatment plan with the information submitted to the health plan for prior authorization satisfies the related requirements under RCW 48.43.761 (c)(2)(ii). The admitting behavioral health organization must provide the health plan with notice of admission within twenty-four hours.
- If a carrier has authorized treatment for a particular length of stay, it cannot shorten the length of the stay approved under that authorization on the grounds it is no longer "medically necessary" under RCW 48.43.761 (2)(c)(iii).
- The provisions of RCW 48.43.761 (3) through (6) apply to admissions that result from approval of a voluntary prior authorization request.

In those cases where there is no medical necessity determination prior to admission, carriers may "pend" a medical necessity review decision, but must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.[4]

4 RCW 48.43.761 (2)(c)(iii).

OIC and HCA have adopted ASAM criteria to define medical necessity for substance use disorder treatment and to define substance use disorder level of care.[5] For all services covered by RCW 48.43.761, ASAM criteria must be incorporated into the patient assessment and support the treatment plan. Health plans and providers are encouraged to collaborate to determine the information needed to ensure medical necessity is met for a requested level of care and how to provide that information to the plans.

5 *See* RCW 41.05.528.

Please direct any questions about this advisory to Jane Beyer, senior health policy advisor, who may be contacted at janeb@oic.wa.gov and phone number 360-725-7043.