WSR 26-19-090
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 18, 2026, 8:10 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 26-12-012.

Title of Rule and Other Identifying Information: WAC 182-501-0160 Exception to the rule—Request for noncovered health care service, and 182-501-0165 Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment.

Hearing Location(s): On October 27, 2026, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. Virtual public hearings are held via Microsoft Teams webinar. To attend, you must register in advance at https://events.gcc.teams.microsoft.com/event/0d7f053a-648a-4726-9cd6-186bde5cf01d@11d0e217-264e-400a-8ba0-57dcc127d72d. After registering, you will receive a confirmation email containing information about joining the public hearing. You will be able to join the public hearing through most standard internet browsers; you do not need to install Microsoft Teams.

Date of Intended Adoption: Not sooner than October 28, 2026.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, beginning September 21, 2026, 8:00 a.m., by October 27, 2026, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Jessica Nguyen, phone 360-725-1174, fax 360-586-9727, telecommunication relay service 711, email arc@hca.wa.gov, by October 9, 2026.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending these rules to comply with CMS-0057-F: Advancing Interoperability and Improving Authorization (42 C.F.R. § 440.230 (e)(4)).

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Statute Being Implemented: RCW 41.05.021 and 41.05.160.

Rule is necessary because of federal law, [42 C.F.R. § 440.230 (e)(4)].

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Blake O'Connor, 626 7th Avenue S.E., Olympia, WA 98501, 360-725-1344; Implementation and Enforcement: Kerry Davis, 626 7th Avenue S.E., Olympia, WA 98501, 360-725-9727.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Explanation of exemptions: HCA is amending these rules to align with the federal requirements found in 42 C.F.R. § 440.230 (e)(4) (also known as CMS-0057-F: Advancing Interoperability and Improving Authorization).

Scope of exemption for rule proposal:

Is fully exempt.

September 18, 2026
Wendy Barcus
Rules Coordinator

RDS-7374.1

AMENDATORY SECTION (Amending WSR 15-18-044, filed 8/27/15, effective 9/27/15)

WAC 182-501-0160 Health care coverage—Exception to rule—Request for a noncovered health care service. A client or the client's provider may request that the medicaid agency or ((~~its~~)) the agency's designee pay for a noncovered health care service. This is called an exception to rule (ETR). The request for ETR must be made before the service is rendered.

(1) The agency's medical director or designee evaluates and considers requests on a case-by-case basis. The agency's medical director has final authority to approve or deny a request for ETR.

(2) The agency or ((~~its~~)) the agency's designee cannot approve an ETR if the requested service is excluded under state statute.

(3) Any item or service for which an ETR is requested must:

(a) Fall within accepted standards and precepts of good medical practice;

(b) Represent cost-effective use of public funds; and

(c) Be submitted to the agency or its designee in writing within ((~~ninety~~)) 90 days of the date of the written notification denying authorization for the noncovered service.

(4) For the agency or ((~~its~~)) the agency's designee to consider the ETR request:

(a) The ((~~client or the~~)) client's health care provider must submit sufficient client-specific information and documentation to the agency's medical director or designee which demonstrate that the client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need.

(b) The client's health care provider must certify that medical treatment or items of service which are covered under the client's Washington apple health program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:

(i) Medically ineffective in the treatment of the client's condition; or

(ii) Inappropriate for that specific client.

(5) Within ((~~fifteen business~~)) seven calendar days of receiving the request, the agency or ((~~its~~)) the agency's designee must send written notification to the provider and the client:

(a) Approving the ETR request;

(b) Denying the ETR request; or

(c) Requesting additional information.

(i) The additional information must be received by the agency or ((~~its~~)) the agency's designee within ((~~thirty~~)) seven calendar days of the date the information was requested.

(ii) The agency or ((~~its~~)) the agency's designee must approve or deny the ETR request within ((~~five business~~)) seven calendar days of receiving the additional information.

(iii) If the requested information is insufficient or not provided within ((~~thirty~~)) seven calendar days, the agency or ((~~its~~)) the agency's designee denies the ETR request.

(6) A client does not have a right to a fair hearing on ETR decisions.

AMENDATORY SECTION (Amending WSR 20-14-057, filed 6/26/20, effective 7/27/20)

WAC 182-501-0165 ((~~Medical and dental~~)) Health care coverage—Fee-for-service (FFS) prior authorization—Determination process for payment authorization. (1) This section applies to fee-for-service (FFS) requests for ((~~medical or dental~~)) health care services and ((~~medical~~)) equipment that:

(a) Are identified as covered services or early and periodic screening, diagnosis, and treatment services; and

(b) Require prior authorization (PA) by the medicaid agency.

(2) The following definitions and those found in chapter 182-500 WAC apply to this section:

"Controlled studies" - Studies in which defined groups are compared with each other to reduce bias.

"Credible evidence" - Type I-IV evidence or evidence-based information from any of the following sources:

- Clinical guidelines
- Government sources
- Independent medical evaluation (IME)
- Independent review organization (IRO)
- Independent technology assessment organizations
- Medical and hospital associations
- Policies of other health plans
- Regulating agencies (for example, the Federal Drug Administration or Department of Health)
- Treating provider
- Treatment pathways

"Evidence-based" - The ordered and explicit use of the best evidence available (see "hierarchy of evidence" in subsection (6)(a) of this section) when making health care decisions.

"Health outcome" - Changes in health status (mortality and morbidity) which result from the provision of health care services.

"Institutional review board (IRB)" - A board or committee responsible for reviewing research protocols and determining whether:

((~~(1)~~)) (a) The rights and welfare of human subjects are adequately protected;

((~~(2)~~)) (b) The risks to people are minimized and are not unreasonable;

((~~(3)~~)) (c) The risks to people are outweighed by the potential benefit to them or by the knowledge to be gained; and

((~~(4)~~)) (d) The proposed study design and methods are adequate and appropriate in the light of stated study objectives.

"Independent review organization (IRO)" - A panel of medical and benefit experts intended to provide unbiased, independent, clinical, evidence-based reviews of adverse decisions.

"Independent medical evaluation (IME)" - An objective medical examination of the client to establish the medical facts.

"Provider" - The person who is responsible for diagnosing, prescribing, and providing medical, dental, or behavioral health services to agency clients.

(3) The agency authorizes, on a case-by-case basis, requests described in subsection (1) of this section when the agency determines the service or equipment is medically necessary as defined in WAC 182-500-070. The process and timelines the agency uses to assess medical necessity ((~~is~~)) are based on:

(a) The evaluation of submitted and obtainable medical, dental, or behavioral health evidence as described in subsections (4) and (5) of this section; ((~~and~~))

(b) The application of the evidence-based rating process described in subsection (6) of this section; and

(c) The timelines contained within this section, except for outpatient drug program benefits which utilize the timeline in chapter 182-530 WAC.

(4) The agency reviews available evidence relevant to a medical, dental, or behavioral health service or equipment to:

(a) Determine its efficacy, effectiveness, and safety;

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Evaluate pertinent client information;

(e) Compare to alternative technologies; and

(f) Identify sources of credible evidence that use and report evidence-based information.

(5) The agency considers and evaluates all available clinical information and credible evidence relevant to the client's condition. The provider responsible for the client's diagnosis, or treatment, or both, must submit with the request credible evidence specifically related to the client's condition including, but not limited to:

(a) A physiological description of the client's disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) Pertinent X-ray and/or imaging reports;

(d) Individual patient records pertinent to the case or request;

(e) Photographs, or videos, or both, if requested; and

(f) Objective medical/dental/behavioral health information such as medically/dentally acceptable clinical findings and diagnoses resulting from physical or behavioral health examinations.

(6) The agency uses the following processes to determine whether a requested service described in subsection (1) is medically necessary:

(a) **Hierarchy of evidence - How defined.** The agency uses a hierarchy of evidence to determine the weight given to available data. The weight of medical evidence depends on objective indicators of its validity and reliability including the nature and source of the evidence, the empirical characteristics of the studies or trials upon which the evidence is based, and the consistency of the outcome with comparable studies. The hierarchy (in descending order with Type I given the greatest weight) is:

(i) Type I: Meta-analysis done with multiple, well-designed controlled studies;

(ii) Type II: One or more well-designed experimental studies;

(iii) Type III: Well-designed, quasi-experimental studies such as nonrandomized controlled, single group pre-post, cohort, time series, or matched case-controlled studies;

(iv) Type IV: Well-designed, nonexperimental studies, such as comparative and correlation descriptive, and case studies (uncontrolled); and

(v) Type V: Credible evidence submitted by the provider.

(b) **Hierarchy of evidence - How classified.** Based on the quality of available evidence, the agency determines if the requested service is effective and safe for the client by classifying it as an **"A," "B," "C,"** or **"D"** level of evidence:

(i) **"A" level evidence:** Shows the requested service or equipment is a proven benefit to the client's condition by strong scientific literature and well-designed clinical trials such as Type I evidence or multiple Type II evidence or combinations of Type II, III, or IV evidence with consistent results (An "A" rating cannot be based on Type III or Type IV evidence alone).

(ii) **"B" level evidence:** Shows the requested service or equipment has some proven benefit supported by:

(A) Multiple Type II or III evidence or combinations of Type II, III, or IV evidence with generally consistent findings of effectiveness and safety (A **"B"** rating cannot be based on Type IV evidence alone); or

(B) Singular Type II, III, or IV evidence in combination with agency-recognized:

(I) Clinical guidelines;

(II) Treatment pathways; or

(III) Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

(iii) **"C" level evidence:** Shows only weak and inconclusive evidence regarding safety, or efficacy, or both. For example:

(A) Type II, III, or IV evidence with inconsistent findings; or

(B) Only Type V evidence is available.

(iv) **"D" level evidence:** Is not supported by any evidence regarding its safety and efficacy, for example that which is considered investigational or experimental.

(c) **Hierarchy of evidence - How applied.** After classifying the available evidence, the agency:

(i) Approves **"A"** and **"B"** rated requests if the service or equipment:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is not more costly than an equally effective alternative treatment.

(ii) Approves a **"C"** rated request only if the provider shows the requested service is the optimal intervention for meeting the client's specific condition or treatment needs, and:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment;

(B) Is less costly to the agency than an equally effective alternative treatment; and

(C) Is the next reasonable step for the client in a well-documented tried-and-failed attempt at evidence-based care.

(iii) Denies **"D"** rated requests unless:

(A) The requested service or equipment has a humanitarian device exemption from the Food and Drug Administration (FDA); or

(B) There is a local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the agency and the requesting provider.

(7) ((~~Within fifteen~~)) For a standard PA request, as expeditiously as the client's health condition requires, but in no case later than seven calendar days of receiving the request from the client's provider, the agency reviews all evidence submitted and:

(a) Approves the request;

(b) Denies the request if the requested service is not medically necessary; or

(c) Requests the provider submit additional justifying information. The agency sends a copy of the request to the client at the same time.

(i) The provider must submit the additional information within ((~~thirty~~)) seven calendar days of the agency's request.

(ii) If the provider submits the requested information within seven calendar days, the agency approves or denies the request within ((~~five business~~)) seven calendar days of the receipt of the additional information.

(iii) If the provider fails to provide the additional information within seven calendar days, the agency will deny the requested service.

(8) For an expedited authorization request, as expeditiously as the client's health condition requires, but in no case later than 72 hours after receiving the request from the client's provider, the agency reviews all evidence submitted and:

(a) Approves the request; or

(b) Denies the request if the requested service is not medically necessary.

(9) When the agency denies all or part of a request for ((~~a~~)) covered health care services or equipment, the agency sends the client and the provider written notice((~~,~~)) within ((~~ten business~~)) seven calendar days of the date the information is received, that:

(a) Includes a statement of the action the agency intends to take;

(b) Includes the specific factual basis for the intended action;

(c) Includes reference to the specific WAC provision upon which the denial is based;

(d) Is in sufficient detail to enable the recipient to:

(i) Learn why the agency's action was taken; and

(ii) Prepare an appropriate response.

(e) Is in sufficient detail to determine what additional or different information might be provided to challenge the agency's determination;

(f) Includes the client's administrative hearing rights;

(g) Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and

(h) Includes examples(s) of "lesser cost alternatives" that permit the affected party to prepare an appropriate response.

((~~(9)~~)) (10) If an administrative hearing is requested, the agency or the client may request an independent review organization (IRO) or independent medical examination (IME) to provide an opinion regarding whether the requested service or equipment is medically necessary. The agency pays for the independent assessment if the agency agrees

that it is necessary, or an administrative law judge orders the assessment.