WAC 284-43-2050 Prior authorization processes. (1) This section applies to health benefit plans as defined in RCW 48.43.005, contracts for limited health care services as defined in RCW 48.44.035, and stand-alone dental and stand-alone vision plans. This section applies to plans issued or renewed on or after January 1, 2018. Unless stated otherwise, this section does not apply to prescription drug services. For health plans as defined in RCW 48.43.005, carriers must meet the requirements of RCW 48.43.830 in addition to the requirements in this section.

(2) A carrier or its designated or contracted representative must maintain a documented prior authorization program description and use evidence-based clinical review criteria. A carrier or its designated or contracted representative must make determinations in accordance with the carrier's current clinical review criteria and use the medical necessity definition stated in the enrollee's plan. The prior authorization program must include a method for reviewing and updating clinical review criteria. A carrier is obligated to ensure compliance with prior authorization requirements, even if they use a third-party contractor. A carrier is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement for its prior authorization program. A carrier or its designated or contracted representative is not required to use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care.

(3) A prior authorization program must meet standards set forth by a national accreditation organization including, but not limited to, National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and Accreditation Association for Ambulatory Health Care in addition to the requirements of this chapter. A prior authorization program must have staff who are properly qualified, trained, supervised, and supported by explicit written, current clinical review criteria and review procedures.

(4) Effective November 1, 2019, a carrier or its designated or contracted representative must have a current and accurate online prior authorization process. All parts of the process that utilize personally identifiable information must be accessed through a secure online process. The online process must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system. The online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) What, if any preservice requirements apply; and

(d) If a prior authorization request is necessary, the following information:

(i) The clinical review criteria used to evaluate the request; and

(ii) Any required documentation.

(5) Effective November 1, 2019, in addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for serv-

ices must have a secure online process for a participating provider or facility to complete a prior authorization request and upload documentation if necessary. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system.

(6) Except for an integrated delivery system, a carrier or its designated or contracted representative must have a method that allows an out-of-network provider or facility to:

(a) Have access to any preservice requirements; and

(b) Request a prior authorization if prior authorization is required for an out-of-network provider or facility.

(7) A carrier or its designated or contracted representative that requires prior authorization for any service must allow a provider or facility to submit a request for a prior authorization at all times, including outside normal business hours.

(8) A carrier or its designated or contracted representative is responsible for maintaining a system of documenting information and supporting evidence submitted by a provider or facility while requesting prior authorization. This information must be kept until the claim has been paid or the appeals process has been exhausted.

(a) Upon request of the provider or facility, a carrier or its designated or contracted representative must remit to the provider or facility written acknowledgment of receipt of each document submitted by a provider or facility during the processing of a prior authorization request.

(b) When information is transmitted telephonically, a carrier or its designated or contracted representative must provide written acknowledgment of the information communicated by the provider or facility.

(9) A carrier or its designated or contracted representative must have written policies and procedures to assure that prior authorization determinations for a participating provider or facility are made within the appropriate time frames.

(a) Time frames must be appropriate to the severity of the enrollee condition and the urgency of the need for treatment, as documented in the prior authorization request.

(b) If the request from the participating provider or facility is not accompanied by all necessary information, the carrier or its designated or contracted representative must inform the provider or facility what additional information is needed and the deadline for its submission as set forth in this section.

(10) For health plans as defined in RCW 48.43.005, the prior authorization time frames for health care services and prescription drugs in RCW 48.43.830 apply.

(a) For purposes of the prior authorization time frames in RCW 48.43.830 and this subsection, the following definitions apply:

(i) "Electronic prior authorization request" means a prior authorization request that is delivered through a two-way communication system that meets the requirements of a secure online prior authorization process or an interoperable electronic process or prior authorization application programming interface.

(ii) "Nonelectronic prior authorization request" means a prior authorization request other than an electronic prior authorization request including, but not limited to, requests delivered through email, a phone call, a text message, a fax, or U.S. mail.

(b) If insufficient information has been provided to the carrier to make a prior authorization determination and the carrier requests

additional information from the provider or facility under RCW 48.43.830, the initial prior authorization request time frames in RCW 48.43.830 apply once the carrier has the necessary information to make a determination. Those time frames are as follows:

(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of receiving the necessary information needed to make the determination.

(ii) For electronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of receiving the necessary information needed to make the determination.

(iii) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of receiving the necessary information needed to make the determination.

(iv) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of receiving the necessary information needed to make the determination.

(11) For purposes of compliance with RCW 48.43.830 effective January 21, 2027, health plans must:

(a) Establish and maintain a prior authorization application programming interface that is consistent with final rules issued by the federal Centers for Medicare and Medicaid Services and published in the federal register, and that indicates that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the carrier's grievance and appeal process under RCW 48.43.535; and

(b) For prior authorization of prescription drugs, a health plan must utilize the fast health care interoperability resources application programming interface for prescription drugs covered under a health plan's medical benefit; and

(c) A carrier may adopt an interoperable electronic process that complies with standards developed by the National Council for Prescription Drug Programs as an alternative to use of the fast health care interoperability resources application programming interface for prior authorization of drugs covered under a health plan's prescription drug benefit.

(12) For limited health care services contracts as defined in RCW 48.44.035, stand-alone dental plans, and stand-alone vision plans, the time frames for carrier prior authorization determination and notification to a participating provider or facility are as follows:

(a) For standard prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within five calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has five calendar days to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility five calendar days to give the neces-

sary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within four calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(b) For expedited prior authorization requests:

(i) The carrier or its designated or contracted representative must make a decision and provide notification within two calendar days.

(ii) If insufficient information has been provided to a carrier or its designated or contracted representative to make a decision, the carrier or its designated or contracted representative has one calendar day to request additional information from the provider or facility.

(A) The carrier or its designated or contracted representative must give a provider or facility two calendar days to give the necessary information to the carrier or its designated or contracted representative.

(B) The carrier or its designated or contracted representative must then make a decision and give notification within two calendar days of the receipt of the information or the deadline for receiving information, whichever is sooner.

(iii) If the time frames for the approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.

(13) A carrier or its designated or contracted representative when conducting prior authorization must:

(a) Accept any evidence-based information from a provider or facility that will assist in the authorization process;

(b) Collect only the information necessary to authorize the service and maintain a process for the provider or facility to submit such records;

(c) If medical records are requested, require only the section(s) of the medical record necessary in that specific case to determine medical necessity or appropriateness of the service to be delivered, to include admission or extension of stay, frequency or duration of service; and

(d) Base review determinations on the medical information in the enrollee's records and obtained by the carrier up to the time of the review determination.

(14) When a provider or facility makes a request for the prior authorization, the response from the carrier or its designated or contracted representative must state if it is approved or denied. If the request is denied, the response must give the specific reason for the denial in clear and simple language. If the reason for the denial is based on clinical review criteria, the criteria must be provided. Written notice of the decision must be communicated to the provider or facility, and the enrollee. A decision may be provided orally, but subsequent written notice must also be provided. A denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.

Whenever the prior authorization relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(15) A prior authorization approval notification for all services must inform the requesting provider or facility, and the enrollee, whether the prior authorization is for a specific provider or facility. The notification must also state if the authorized service may be delivered by an out-of-network provider or facility and if so, disclose to the enrollee the financial implications for receiving services from an out-of-network provider or facility.

Whenever the notification relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

(16) A provider or facility may appeal a prior authorization denial to the carrier or its designated or contracted representative.

(17) Prior authorization determinations shall expire no sooner than 45 days from date of approval. This requirement does not supersede RCW 48.43.039.

(18) In limited circumstances when an enrollee has to change plans due to a carrier's market withdrawal as defined in RCW 48.43.035 (4)(d) and 48.43.038 (3)(d), the subsequent carrier or its designated or contracted representative must recognize the prior authorization of the previous carrier until the new carrier's prior authorization process has been completed and its authorized treatment plan has been initiated. The subsequent carrier or its designated or contracted representative must ensure that the enrollee receives the previously authorized initial service as an in-network service. Enrollees must present proof of the prior authorization.

(a) For medical services, a carrier or its designated or contracted representative must recognize a prior authorization for at least 30 days or the expiration date of the original prior authorization, whichever is shorter.

(b) For pharmacy services, a carrier or its designated or contracted representative must recognize a prior authorization for the initial fill, or until the prior authorization process of the new carrier or its designated or contracted representative has been completed.

(19) Prior authorization for a facility-to-facility transport that requires prior authorization can be performed after the service is delivered. Authorization can only be based on information available to the carrier or its designated or contracted representative at the time of the prior authorization request.

(20) A carrier or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee.

(21) A carrier or its designated or contracted representative must have a method that allows an enrollee, provider or facility to make a predetermination request when provided for by the plan.

(22) Predetermination notices must clearly disclose to the enrollee and requesting provider or facility, that the determination is not a prior authorization and does not guarantee services will be covered. The notice must state "A predetermination notice is not a prior authorization and does not guarantee services will be covered." Predetermination notices must be delivered within five calendar days of re-

ceipt of the request. Predetermination notices will disclose to a provider or facility for an enrollee's plan:

(a) If a service is a benefit;

(b) If a prior authorization request is necessary;

(c) If any preservice requirements apply;

(d) If a prior authorization request is necessary or if a medical necessity review will be performed after the service has been delivered, the following information:

(i) The clinical review criteria used to evaluate the request; and

(ii) Any required documentation.

(e) Whenever a predetermination notice relates to a protected individual, as defined in RCW 48.43.005, the health carrier must follow RCW 48.43.505.

[Statutory Authority: RCW 48.02.060, 48.49.110, 2024 c 366, 2025 c 25, and 2025 c 171. WSR 26-01-148 (Matter R 2025-12), s 284-43-2050, filed 12/19/25, effective 1/19/26. Statutory Authority: RCW 48.02.060, 48.43.0161, and 48.43.520. WSR 25-02-084 (Matter R 2024-03), s 284-43-2050, filed 12/27/24, effective 1/27/25. Statutory Authority: RCW 48.02.060, 48.43.505, and 48.43.5051. WSR 20-24-120, § 284-43-2050, filed 12/2/20, effective 1/2/21. Statutory Authority: RCW 48.02.060, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, and 48.165.030. WSR 17-12-069 (Matter No. R 2016-19), § 284-43-2050, filed 6/5/17, effective 1/1/18.]