RCW 48.165.045 Lead organization tasks—Implementation guidelines—Code development and standardization—Denial review process. (1) By December 31, 2010, the lead organization shall develop implementation guidelines and promote widespread adoption of such guidelines for:

(a) The use of the national correct coding initiative code edit policy by payors and providers in the state;

(b) Publishing any variations from component codes, mutually exclusive codes, and status b codes by payors in a manner that makes for simple retrieval and implementation by providers;

(c) Use of health insurance portability and accountability act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(d) The processing of corrections to claims by providers and payors; and

(e) A standard payor denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common standards body or process exists and multiple conflicting sources are in use by payors and providers.

(2) By October 31, 2010, the lead organization shall develop a proposed set of goals and work plan for additional code standardization efforts for 2011 and 2012.

(3) Nothing in this section or in the guidelines developed by the lead organization shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. Though such temporary code edits are not required to be disclosed to providers, the guidelines shall require that:

(a) Each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such an edit; and

(b) The provider have access to the payor's review and appeal process to challenge the payor's adjudication decision, provided that nothing in this subsection (3)(b) shall be construed to modify the rights or obligations of payors or providers with respect to procedures relating to the investigation, reporting, appeal, or prosecution under applicable law of potentially fraudulent billing activities. [2009 c 298 s 9.]