RCW 48.43.0161 Prior authorization practices—Carrier annual reporting requirements—Commissioner's standardized report. (1) By October 1, 2020, and annually thereafter, for individual and group health plans issued by a carrier that has written at least one percent of the total accident and health insurance premiums written by all companies authorized to offer accident and health insurance in Washington in the most recently available year, the carrier shall report to the commissioner the following aggregated and deidentified data related to the carrier's prior authorization practices and experience for the prior plan year:

(a) Lists of the 10 inpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(b) Lists of the 10 outpatient medical or surgical codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(c) Lists of the 10 inpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(d) Lists of the 10 outpatient mental health and substance use disorder service codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved;

(e) Lists of the 10 durable medical equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(f) Lists of the 10 diabetes supplies and equipment codes:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each code and the percent of approved requests for each code; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each code and the percent of requests that were initially denied and then subsequently approved for each code;

(g) Lists of the 10 prescription drugs:

(i) With the highest total number of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each prescription drug;

(ii) With the highest percentage of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each prescription drug and the percent of approved requests for each prescription drug; and

(iii) With the highest percentage of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each prescription drug and the percent of requests that were initially denied and then subsequently approved for each prescription drug; and

(h) The average determination response time in hours for prior authorization requests to the carrier with respect to each code

reported under (a) through (f) of this subsection for each of the
following categories of prior authorization:
    (i) Expedited decisions;
    (ii) Standard decisions; and
    (iii) Extenuating circumstances decisions.
    (2) By January 1, 2021, and annually thereafter, the commissioner
shall aggregate and deidentify the data collected under subsection (1)
of this section into a standard report and may not identify the name
of the carrier that submitted the data. The commissioner must make the
report available to interested parties.
    (3) The commissioner may request additional information from
carriers reporting data under this section.
    (4) The commissioner may adopt rules to implement this section.
In adopting rules, the commissioner must consult stakeholders
including carriers, health care practitioners, health care facilities,
and patients.
    (5) For the purpose of this section, "prior authorization" means
a mandatory process that a carrier or its designated or contracted
representative requires a provider or facility to follow before a
service is delivered, to determine if a service is a benefit and meets
the requirements for medical necessity, clinical appropriateness,
level of care, or effectiveness in relation to the applicable plan,
including any term used by a carrier or its designated or contracted
representative to describe this process. [2023 c 382 s 4; 2020 c 316
s 1.]

    Effective date—2023 c 382 s 4: "Section 4 of this act takes
effect January 1, 2024." [2023 c 382 s 5.]