Chapter 284-43B WAC
BALANCE BILLING

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WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-43B-080 Effective date. [Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-080, filed 11/19/19, effective 12/20/19.] Repealed by WSR 23-01-110 (Matter R 2022-02), filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060.

WAC 284-43B-010 Definitions. (1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection (2) of this section.

(2) The following definitions shall apply throughout this chapter:

(a) "Air ambulance service" has the same meaning as defined in RCW 48.43.005.

(b) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(c) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider, facility, behavioral health emergency services provider or air ambulance service provider for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of cost-sharing allowed under WAC 284-43B-020.

(d) "Behavioral health emergency services provider" has the same meaning as defined in RCW 48.43.005.

(e) "De-identified" means, for the purposes of this rule, the removal of all information that can be used to identify the patient from whose medical record the health information was derived.

(f) "Emergency medical condition" has the same meaning as defined in RCW 48.43.005.

(g) "Emergency services" has the same meaning as defined in RCW 48.43.005.

(h) "Facility" or "health care facility" means:

(i) With respect to the provision of emergency services, a hospital or freestanding emergency department licensed under chapter 70.41 RCW (including an "emergency department of a hospital" or "independent freestanding emergency department" described in section 2799A-1(a) of the Public Health Service Act (42 U.S.C. Sec. 300gg-111(a) and 45

C.F.R. Sec. 149.30)) or a behavioral health emergency services provider; and

(ii) With respect to provision of nonemergency services, a hospital licensed under chapter 70.41 RCW, a hospital outpatient department, a critical access hospital or an ambulatory surgical facility licensed under chapter 70.230 RCW (including a "health care facility" described in section 2799A-1(b) of the Public Health Service Act (42 U.S.C. Sec. 300gg-111(b) and 45 C.F.R. Sec. 149.30)).

(i) "Hospital outpatient department" means an entity or site that provides outpatient services and:

(i) Is a provider-based facility under 42 C.F.R. Sec. 413.65;

(ii) Charges a hospital facility fee in billing associated with the receipt of outpatient services from the entity or site; or

(iii) Bills the consumer or their health plan under a hospital's national provider identifier or federal tax identification number.

(j) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case reimbursement agreement between a provider or facility and a carrier used for the purpose described in WAC 284-170-200 constitutes a contract exclusively for purposes of this definition under the Balance Billing Protection Act and is limited to the services and parties to the agreement.

(k) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" has the same meaning as defined in RCW 48.43.005.

(l) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to a nonparticipating provider for emergency services or for nonemergency health care services performed by nonparticipating providers at certain participating facilities.

(m) "Out-of-network" or "nonparticipating" has the same meaning as defined in RCW 48.43.005.

(n) "Provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law, or an employee or agent of a person acting in the course and scope of his or her employment, that provides emergency services, or nonemergency health care services at certain participating facilities.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-010, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-010, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-010, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-015 Coverage of emergency services. (1) Coverage of emergency services is governed by RCW 48.43.093. Emergency services, as defined in RCW 48.43.005, include services provided after an enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabili-

zation services relate to medical, mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant person, the health of a person or their unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(2) A carrier may require notification of stabilization or inpatient admission of an enrollee as provided in RCW 48.43.093. Regardless of such notification, payment and cost-sharing for poststabilization services provided by a nonparticipating facility, provider or behavioral health emergency services provider and dispute resolution related to those services are governed by RCW 48.49.040 and 48.49.160.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-015, filed 12/19/22, effective 1/19/23.]

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services from a nonparticipating facility, provider, or behavioral health emergency services provider, any nonemergency health care services performed by a nonparticipating provider at certain participating facilities, or any air ambulance services from a nonparticipating provider:

(a) The enrollee satisfies their obligation to pay for the health care services if they pay the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be calculated as if the total amount charged for the services were equal to:

(i) For emergency services other than services provided by emergency behavioral health services providers, for nonemergency health care services performed by a nonparticipating provider at certain participating facilities, and for air ambulance services, the lesser of the qualifying payment amount, as determined in accordance with 45 C.F.R. Sec. 149.140, or billed charges; and

(ii) For services provided by emergency behavioral health services providers, the qualifying payment amount, as determined in accordance with 45 C.F.R. Sec. 149.140. The carrier must provide an explanation of benefits to the enrollee and the nonparticipating provider, facility, emergency behavioral health services provider or air ambulance provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, nonparticipating provider, nonparticipating facility, nonparticipating behavioral health emergency services provider or nonparticipating air ambulance provider and any agent, trustee, or assignee of the carrier, nonparticipating provider, nonparticipating facility, nonparticipating emergency behavioral health services provider or nonparticipating air ambulance provider must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the nonparticipating provider, nonparticipating facility, or nonparticipating emergency behavioral health services provider and any agent, trustee, or assignee of the nonparticipating provider, nonparticipating facility or nonparticipating behavioral health emergency services provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this sub-

section. This does not impact the provider's, facility's, or behavioral health emergency services provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For nonemergency health care services performed by nonparticipating providers at certain participating facilities, the nonparticipating provider and any agent, trustee, or assignee of the nonparticipating provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services, nonemergency health care services performed by nonparticipating providers at certain participating facilities and air ambulance services, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid or incurred by the enrollee for a nonparticipating provider's, facility's, behavioral health emergency services provider's or air ambulance provider's services in the same manner as cost-sharing for health care services provided by a participating provider, facility, behavioral health emergency services provider, or air ambulance services provider and must apply any cost-sharing amounts paid or incurred by the enrollee for such services toward the enrollee's deductible and maximum out-of-pocket payment obligation.

(e) If the enrollee pays a nonparticipating provider, nonparticipating facility, nonparticipating behavioral health emergency services provider or nonparticipating air ambulance services provider an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the nonparticipating provider, nonparticipating facility, nonparticipating behavioral health emergency services provider or nonparticipating air ambulance services provider must refund any amount in excess of the in-network cost-sharing amount to the enrollee within 30 business days of the nonparticipating provider, nonparticipating facility, nonparticipating behavioral health emergency services provider or nonparticipating air ambulance services provider's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days.

(2) The carrier must make payments for health care services described in RCW 48.49.020, provided by a nonparticipating provider, nonparticipating facility, nonparticipating behavioral health emergency services provider or nonparticipating air ambulance services provider directly to the provider or facility, rather than the enrollee.

(3) A health care provider, health care facility, behavioral health emergency services provider or air ambulance service provider may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of RCW 48.49.020 and 48.49.030 or sections 2799A-1 et seq. of the Public Health Service Act and federal regulations adopted to implement those sections of P.L. 116-260. This prohibition supersedes any provision of sections 2799A-1 et seq. of the Public Health Service Act and federal regulations adopted to implement those sections of P.L. 116-260 that would authorize a provider or facility to ask a patient to consent to waive their balance billing protections.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-020, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-020, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-020, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-030 Out-of-network claim payment and placing a claim into dispute. For services described in RCW 48.49.020(1) (other than air ambulance services) provided prior to July 1, 2023, or a later date determined by the commissioner, and for services provided by a nonparticipating emergency behavioral health services provider if the federal government does not authorize use of the federal independent dispute resolution system for these disputes, the allowed amount paid to a nonparticipating provider or facility for emergency services and nonemergency health care services performed by nonparticipating providers at certain participating facilities, shall be a commercially reasonable amount, based on payments for the same or similar services provided in the same or a similar geographic area.

(1) Within 30 calendar days of receipt of a claim from a nonparticipating provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The amount actually paid to a nonparticipating provider by a carrier may be reduced by the applicable consumer cost-sharing determined under WAC 284-43B-020 (1)(a). The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the nonparticipating provider or facility to the carrier must include the following information:

(a) Patient name;

(b) Patient date of birth;

(c) Provider name;

(d) Provider location;

(e) Place of service, including the name and address of the facility in which, or on whose behalf, the service that is the subject of the claim was provided;

(f) Provider federal tax identification number;

(g) Federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number;

(h) Date of service;

(i) Procedure code; and

(j) Diagnosis code.

(2) If the nonparticipating provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than 30 calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

(3) If the nonparticipating provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have 30

calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the nonparticipating provider or facility do not agree to a commercially reasonable payment amount within the 30-calendar day period under subsection (3) of this section, and the carrier, nonparticipating provider or nonparticipating facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in RCW 48.49.040.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-030, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-030, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-030, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-032 Applicable dispute resolution system. (1) Effective for services provided on or after July 1, 2023, or a later date determined by the commissioner, services described in RCW 48.49.020(1) other than air ambulance services are subject to the independent dispute resolution process established in sections 2799A-1 and 2799A-2 of the Public Health Service Act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and federal regulations implementing those sections of P.L. 116-260 (enacted December 27, 2020). Until July 1, 2023, or a later date determined by the commissioner, the arbitration process in this chapter governs the dispute resolution process for those services.

(2) Effective for services provided on or after July 1, 2023, or a later date determined by the commissioner, if the federal independent dispute resolution process is available to the state, behavioral emergency services provider services described in RCW 48.49.020(3) are subject to the independent dispute resolution process established in section 2799A-1 and 2799A-2 of the Public Health Service Act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and federal regulations implementing those sections of P.L. 116-260 (enacted December 27, 2020). Until July 1, 2023, or a later date determined by the commissioner, or if the federal independent dispute resolution process is not available to the state for resolution of these disputes, the arbitration process in this chapter governs the dispute resolution process for those services.

(3) The office of the insurance commissioner must provide a minimum of four months advance notice of the date on which the dispute resolution process will transition to the federal independent dispute resolution process. The notice must be posted on the website of the office of the insurance commissioner.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-032, filed 12/19/22, effective 1/19/23.]

WAC 284-43B-035 Arbitration initiation and selection of arbitrator. (1)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than 10 calendar days following completion of the period of good faith negotiation under WAC 284-43B-030(3)

using the arbitration initiation request form found in Appendix A of this rule. A request must be submitted electronically through the website of the office of the insurance commissioner. When multiple claims are addressed in a single arbitration proceeding, subsection (3) of this section governs calculation of the 10 calendar days. Each arbitration initiation request must be submitted to the commissioner individually and constitutes a distinct arbitration proceeding unless consolidation of requests is authorized by a court under chapter 7.04A RCW. The commissioner will assign a unique number or designation to each arbitration initiation request. The parties must include that designation in all communication related to that request. Any information submitted to the commissioner with the arbitration initiation request must be included in the notice to the noninitiating party under RCW 48.49.040. A provider or facility initiating arbitration must send the arbitration initiation request form to the email address appearing on the website established by the designated lead organization for administration simplification in Washington state under (c) of this subsection. Any patient information submitted to the commissioner with an arbitration initiation request form must be de-identified to ensure that protected health information is not disclosed.

(b) The written notification to the commissioner must be made electronically and provide dates related to each of the time period limitations described in WAC 284-43B-030 (1) through (3) and subsection (1)(a) of this section. The commissioner's review of the arbitration initiation request form is limited to the information necessary to determine that the request has been timely submitted and is complete. The commissioner's review does not include a review of whether particular claims included in the request are subject to chapter 48.49 RCW or whether claims are appropriately bundled under subsection (3) of this section. A party seeking to challenge whether a claim is subject to chapter 48.49 RCW or whether claims are appropriately bundled may raise those issues during arbitration.

(c) Each carrier must provide the designated lead organization for administrative simplification in Washington state with the email address and telephone number of the carrier's designated contact for receipt of notices to initiate arbitration. The email address and phone number provided must be specific to the carrier staff responsible for receipt of notices or other actions related to arbitration proceedings. The initial submission of information to the designated lead organization must be made on or before November 10, 2020. The carrier must keep its contact information accurate and current by submitting updated contact information to the designated lead organization as directed by that organization.

(2) Within 10 business days of a party notifying the commissioner and the noninitiating party of intent to initiate arbitration, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement must prohibit either party from sharing or making use of any confidential or proprietary information acquired or used for purposes of one arbitration in any subsequent arbitration proceedings. The nondisclosure agreement must not preclude the arbitrator from submitting the arbitrator's decision to the commissioner under RCW 48.49.040 or impede the commissioner's duty to prepare the annual report under RCW 48.49.050.

(3) If a nonparticipating provider or nonparticipating facility chooses to address multiple claims in a single arbitration proceeding as provided in RCW 48.49.040, notification must be provided no later than 10 calendar days following completion of the period of good faith

negotiation under WAC 284-43B-030(3) for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:

(a) Involve identical carrier and provider, provider group or facility parties. Items and services are billed by the same provider, provider group or facility if the items or services are billed with the same national provider identifier or tax identification number;

(b) Involve the same or similar items and services. The services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as current procedural terminology (CPT) codes with modifiers, if applicable, health care common procedure coding system (HCPCS) with modifiers, if applicable, or diagnosis-related group (DRG) codes with modifiers, if applicable; and

(c) Occur within the same 30-business-day period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than 30 business days prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.

(4) A notification submitted to the commissioner later than 10 calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. Any revision to a previously timely submitted arbitration initiation request form must be submitted to the commissioner within the 10 calendar day period applicable to submission of the original request. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.

(5) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The commissioner will use the email addresses for the initiating party and the noninitiating party indicated on the arbitration initiation request form for all communication related to the arbitration request. The arbitrator selection process must be completed within 20 calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(a) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of two individual arbitrators and three arbitration entities within five calendar days of receipt of notice from the parties under this subsection. Each party is responsible for reviewing the list of five arbitrators and arbitration entities and notifying the commissioner and the other party within three calendar days of receipt of the list:

(i) Whether they are taking the opportunity to veto up to two of the five arbitrators or arbitration entities on this list, and if so, which arbitrators or arbitration entities have been vetoed; and

(ii) If there is a conflict of interest as described in subsection (6) of this section with any of the arbitrators or arbitration entities on the list, to avoid the commissioner assigning an arbitrator or arbitration entity with a conflict of interest to an arbitration.

(b) If, after the opportunity to veto up to two of the five named arbitrators or arbitration entities on the list of five arbitrators and arbitration entities sent by the commissioner to the parties, more than one arbitrator or arbitration entity remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators or arbitration entities. The commissioner will choose the arbitrator from among the remaining arbitrators on the list. If a party fails to timely provide the commissioner with notice of their veto, the commissioner will choose the arbitrator from among the remaining arbitrators or arbitration entities on the list.

(6) Before accepting any appointment, an arbitrator shall ensure that there is no conflict of interest that would adversely impact the arbitrator's independence and impartiality in rendering a decision in the arbitration. A conflict of interest includes (a) current or recent ownership or employment of the arbitrator or a close family member by any health carrier; (b) serves as or was employed by a physician, health care provider, or a health care facility; (c) has a material professional, familial, or financial conflict of interest with a party to the arbitration to which the arbitrator is assigned.

(7) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(8) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

(9) Where a dispute resolution matter initiated under sections 2799A-1 and 2799A-2 of the Public Health Service Act (42 U.S.C. Secs. 300gg-111 and 300gg-112) and federal regulations implementing those provisions of P.L. 116-260 (enacted December 27, 2020) results in a determination by a certified independent dispute resolution entity that such process does not apply to the dispute or to portions thereof, RCW 48.49.040 (3)(b) governs initiation of arbitration under this chapter.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-035, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-035, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-037 Arbitration proceedings. (1) For purposes of calculating the date that written submissions to the arbitrator under RCW 48.49.040 are due, final selection of the arbitrator occurs on the date that the commissioner sends by electronic transmittal the notice of selection to the arbitrator. The parties must be copied on such notice.

(2) Good cause for purposes of delay in written submissions to the arbitrator under RCW 48.49.040 includes a stipulation that the parties intend to complete settlement negotiations prior to making such submissions to the arbitrator.

(3) If the parties agree on an out-of-network rate for the services at issue after submitting an arbitration initiation request but

before the arbitrator has made a decision, they must provide notice to the commissioner as provided in RCW 48.49.040(7).

(4) If an initiating party withdraws an arbitration initiation request at any point before the arbitrator has made a decision, the party must submit to the commissioner notice of the date of the withdrawal of the request, as soon as possible, but no later than three business days after the date of the withdrawal.

(5) Any enrollee or patient information submitted to the arbitrator in support of the final offer shall be de-identified to ensure that protected health information is not disclosed.

(6) The decision of the arbitrator is final and binding on the parties and is not subject to judicial review. The arbitrator must submit to the commissioner:

(a) Their decision, including an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision; and

(b) The information required in RCW 48.49.050 using the form found in Appendix B to this rule, or for arbitration proceedings under RCW 48.49.135, using the form found in Appendix C to this rule.

(7)(a) For the calendar year beginning January 1, 2023, arbitrators must charge a fixed fee for single claim proceedings within the range of $200-$650. If an arbitrator chooses to charge a different fixed fee for bundled claim proceedings, that fee must be within the range of $268-$800. Beginning January 1, 2024, and January 1st of each year thereafter, the arbitrator may adjust the fee range by the annual consumer price index-urban as determined annually by the United States Bureau of Labor Statistics.

(b) Expenses incurred during arbitration, including the arbitrator's expenses and fees, but not including attorneys' fees, must be divided equally among the parties to the arbitration. Arbitrator fees must be paid to the arbitrator by the parties within 30 calendar days of receipt of the arbitrator's decision by the parties.

(c) If the parties reach an agreement before the arbitrator makes their decision, the arbitrator fees must be paid by the parties within 30 calendar days of the date the settlement is reported to the commissioner as required under RCW 48.49.040.

(8) RCW 48.49.040(13) governs arbitration proceedings initiated under RCW 48.49.135. The determination of the rate to be paid to the out-of-network or nonparticipating provider must be accomplished through a single arbitration proceeding.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-037, filed 12/19/22, effective 1/19/23.]

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. (1) To implement RCW 48.49.170, carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 48.49 RCW or section 2799A-1 et seq. of the Public Health Service Act (42 U.S.C. Sec. 300gg-111 et seq.) and federal regulations implementing those provisions of P.L. 116-260 available to providers and facilities by:

(a) Using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Eligibility Benefit Response (271) transaction information through use of

the most appropriate standard message that is placed in a standard location within the 271 transaction;

(b) Beginning April 1, 2021, and until December 31, 2022, using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Claim Payment and Remittance Advice (835) transaction through compliant use of the X12 industry standard Remark Code N830 to indicate that the claim was processed in accordance with this state's balance billing rules;

(c) Beginning January 1, 2023, using the appropriate version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Claim Payment and Remittance Advice (835) transaction through compliant use of the applicable X12 industry standard Remark Code to indicate whether a claim was processed in accordance with this state's balance billing rules or the federal No Surprises Act.

(2) The designated lead organization for administrative simplification in Washington state:

(a) After consultation with carriers, providers and facilities through a new or an existing workgroup or committee, must post the language of the most appropriate standard message and the location within the 271 transaction in which the message is to be placed on its website on or before November 1, 2022;

(b) Must post on its website on or before December 1, 2020, instructions on compliant use of the X12 industry standard Remark Code N830 in the X12 Health Care Claim Payment and Remittance Advice (835) transaction;

(c) Must post on its website on or before December 1, 2022, instructions on compliant use of the appropriate X12 industry standard Remark code or codes as provided in subsection (1)(c) of this section; and

(d) Must post on its website on or before December 1, 2020, the information reported by carriers under WAC 284-43B-035(1).

(3) A link to the information referenced in subsection (2) of this section also must be posted on the website of the office of the insurance commissioner.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-040, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-040, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-040, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-050 Notice of consumer rights and transparency. (1) The commissioner shall develop a standard template for a notice of consumer protections from balance billing under the Balance Billing Protection Act and the federal No Surprises Act (P.L. 116-260). The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public website of the office of the insurance commissioner.

(2) The standard template for the notice of consumer protections developed under subsection (1) of this section must be provided to consumers enrolled in any health plan issued in Washington state as follows:

(a) Carriers must:

(i) Include the notice in the carrier's communication to an enrollee, in electronic or any other format, that authorizes nonemergen-

cy services to be provided at facilities referenced in WAC 284-43B-010 (2)(h)(ii);

(ii) Include the notice in each explanation of benefits sent to an enrollee for items or services with respect to which the requirements of RCW 48.49.020 and WAC 284-43B-020 apply;

(iii) Post the notice on their website in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency health care services performed by nonparticipating providers at certain participating facilities; and

(iv) Provide the notice to any enrollee upon request.

(b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than 50 employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act or the federal No Surprises Act (P.L. 116-260):

(A) Include the notice in any communication to a patient, in electronic or any other format related to scheduling of nonemergency health care services performed by nonparticipating providers at certain participating facilities. Text messaging used as a reminder or follow-up after a patient has already received the full text of the notice under this subsection may provide the notice through a link to the provider's webpage that takes the patient directly to the notice. Telephone calls to patients following the patient's receipt of the full text of the notice under this subsection do not need to include the notice; and

(B) For facilities providing emergency services, including behavioral health emergency services providers, provide or mail the notice to a patient within 72 hours following a patient's receipt of emergency services.

(ii) Post the notice on their website, if the provider, behavioral health emergency services provider or facility maintains a website, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider, behavioral health emergency services provider or facility is an in-network provider;

(iii) If services were provided at a health care facility or in connection with a visit to a health care facility, provide the notice to patients no later than the date and time on which the provider or facility requests payment from the patient, or with respect to a patient from who the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the carrier; and

(iv) Provide the notice upon request of a patient.

(3) The notice required in this section may be provided to a patient or an enrollee electronically if it includes the full text of the notice and if the patient or enrollee has affirmatively chosen to receive such communications from the carrier, provider, or facility electronically. Except as authorized in subsection (2)(b)(i)(A) of this section, the notice may not be provided through a hyperlink in an electronic communication.

(4) For claims processed on or after July 1, 2020, when processing a claim that is subject to the balance billing prohibition in RCW 48.49.020, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number.

(5) Carriers must ensure that notices provided under this subsection are inclusive for those patients who may have disabilities or limited-English proficiency, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965. To assist in meeting this language access requirement, carriers may use translated versions of the notice of consumer protections from balance billing posted on the website of the office of the insurance commissioner.

(6) A facility, behavioral health emergency services provider or health care provider meets its obligation under RCW 48.49.070 or 48.49.080, to include a listing on its website of the carrier health plan provider networks in which the facility or health care provider participates by posting this information on its website for in-force contracts, and for newly executed contracts within 14 calendar days of receipt of the fully executed contract from a carrier. If the information is posted in advance of the effective date of the contract, the date that network participation will begin must be indicated.

(7) Not less than 30 days prior to executing a contract with a carrier:

(a)(i) A hospital, freestanding emergency department, behavioral health emergency services provider or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups that have privileges to practice at the hospital, freestanding emergency department, behavioral health emergency services provider or ambulatory surgical facility;

(ii) A hospital, hospital outpatient department, critical access hospital or ambulatory surgical center must provide the carrier with a list of the nonemployed providers or provider groups that are contracted to provide nonemergency health care services at the facility.

(b) The list must include the name of the provider or provider group, mailing address, federal tax identification number or numbers and contact information for the staff person responsible for the provider's or provider group's contracting.

(c) Any facility providing carriers information under this subsection must notify the carrier within 30 days of a removal from or addition to the nonemployed provider list. The facility also must provide an updated list of these providers within 14 calendar days of a written request for an updated list by a carrier.

(8) A participating provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-050, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-050, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-050, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-060 Enforcement. (1)(a) If the commissioner has cause to believe that any health facility, behavioral health emergency services provider or provider has engaged in a pattern of unresolved violations of RCW 48.49.020 or 48.49.030, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

(b) In determining whether there is cause to believe that a health care provider, behavioral health emergency services provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(i) Whether there is cause to believe that the health care provider, behavioral health emergency services provider or facility has committed two or more violations of RCW 48.49.020 or 48.49.030;

(ii) Whether the health care provider, behavioral health emergency services provider or facility has failed to submit claims to carriers containing all of the elements required in WAC 284-43B-030(1) on multiple occasions, putting a consumer or consumers at risk of being billed for services to which the prohibition in RCW 48.49.020 applies;

(iii) Whether the health care provider, behavioral health emergency services provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of RCW 48.49.020 or 48.49.030; and

(iv) Whether, subsequent to correction of previous violations, additional violations have occurred.

(c) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider, behavioral health emergency services provider or facility with an opportunity to cure the alleged violations or explain why the actions in question did not violate RCW 48.49.020 or 48.49.030.

(2) In determining whether a carrier has engaged in a pattern of unresolved violations of any provision of this chapter, the commissioner shall consider, but is not limited to, consideration of the following:

(a) Whether a carrier has failed to timely respond to arbitration initiation request notifications from providers or facilities;

(b) Whether a carrier has failed to comply with the requirements of WAC 284-43-035 related to choosing an arbitrator or arbitration entity;

(c) Whether a carrier has met its obligation to maintain current and accurate carrier contact information related to initiation of arbitration proceedings under WAC 284-43-035;

(d) Whether a carrier has complied with the requirements of WAC 284-43-040;

(e) Whether a carrier has complied with the consumer notice requirements under WAC 284-43-050; and

(f) Whether a carrier has committed two or more violations of chapter 48.49 RCW or this chapter.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-060, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-060, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-060, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-070 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in RCW 48.49.020 through 48.49.040 and 48.49.160, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by RCW 48.49.020 through 48.49.040, 48.49.160 and rules adopted to implement those sections of law. If the form is completed by the self-funded group health plan, the plan must inform any entity that administers the plan of their election to participate. The form will be posted on the commissioner's public website for use by self-funded group health plans.

(2) A self-funded group health plan election to participate is for a full year. The plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least 15 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) A self-funded plan operated by an out-of-state employer that has at least one employee who resides in Washington state may elect to participate in balance billing protections as provided in RCW 48.49.130 on behalf of their Washington state resident employees and dependents. If a self-funded group health plan established by Washington state employer has elected to participate in balance billing protections under RCW 48.49.130 and has employees that reside in other states, those employees are protected from balance billing when receiving care from a Washington state provider.

(5) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-070, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-070, filed 11/2/20, effective 12/3/20. Statutory Authority: RCW 48.02.060, 48.49.060, and 48.49.110. WSR 19-23-085, § 284-43B-070, filed 11/19/19, effective 12/20/19.]

WAC 284-43B-075 Severability. If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.

[Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-075, filed 11/2/20, effective 12/3/20.]

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

To be completed by OIC	OIC Tracking Number:

Balance Billing Protection Act Arbitration Initiation Request Form

Read the information on the back of the form. Submit completed form to: BBPA_Arbitration@oic.wa.gov

1. VERIFICATION: *You must check all applicable boxes or this will be rejected.*	
	The patient's plan is regulated by the OIC or is a self-funded group health plan that has elected to participate in the BBPA *(See information on back.)* IF NOT, DO NOT SUBMIT.
	I have attached a copy of the notice of payment that shows **the date(s) of payments** and attest that the most recent date of payment was in the last 40 days. IF IT'S NOT, IT'S UNTIMELY. DO NOT SUBMIT.
	I have not attached anything that requires encryption or password protection.
	If this is a request for multiple claims, I have checked that all the claims involve the same carrier and provider/facility, all claims involve the same procedural code, or comparable code under a different procedural system, and all claims occur within the same 30 business day period. IF NOT, YOU MUST SUBMIT INDIVIDUAL CLAIMS.
	The other party has been included as a courtesy copied recipient to this emailed request. Their email address has been verified and is the correct contact.

2. DATE CHECK:	
(a) Date of most recent payment – *must be within last 40 days or will be rejected.*	**(b) Date of completion of 30-day** period of good faith negotiation
(c) Date of notice to non-initiating party (notice to initiate arbitration)	**(d) Date(s) of service**. If multiple claims, note the date of service for each claim

3. FILING INFORMATION:		
If the person filing the request to initiate arbitration is filing on behalf of a provider, facility or carrier, please provide the following information: Please indicate if you are a legal representative of the filing party.		
Name(s):		
Address:	Telephone:	Email:

4. INITIATING PARTY:		
The requesting entity is a: [ ] Health care facility *If checked, provide License type: [ ] Health care provider *If checked, provide Specialty type: [ ] Carrier/Third Party Administrator		
Name(s):		
Address:	Telephone:	Email:

5. NON-INITIATING PARTY:		
The non-initiating party is a: [ ] Carrier/third-party administrator [ ] Health care [ ] provider [ ] facility		
Name:		
Address:	Telephone:	Email:

6. DESCRIPTION OF HEALTH CARE SERVICES PROVIDED: (including any applicable CPT codes)
Description:

7. HEALTH CARE SERVICE PROVIDER INFORMATION:
Performing provider name:

Additional questions and important information on the back of this form, please review and complete prior to submitting this request.

7. HEALTH CARE SERVICE PROVIDER INFORMATION CONTINUED:
Facility where services were provided:
County where services were provided:
8. ADDITIONAL INFORMATION:
(a) Group/plan number(s):
(b) Claim number(s):
(c) Initiating party's final offer:

1. This form and any attachments submitted will become public records and are subject to public disclosure laws. Do not provide sensitive or confidential information that is not necessary for the OIC to assign the claim to arbitration (you will have the opportunity to submit relevant information during the arbitration). OIC may dispose of any documents filed that are not necessary to process a claim for arbitration. Personal health information (PHI) disclosed to OIC is not subject to public disclosure under RCW 48.02.068.

2. Only claim payments made in connection with (1) health insurance plans regulated by OIC; and (2) self- funded group health plans that have elected to participate in balance billing protections can use the arbitration process. Examples of health insurance plans that are not included are:

- Medicare and Medicaid
- Federal employee benefit plans

Please check the list of self-funded group health plans at https://www.insurance.wa.gov/self-funded-group-health-plans to determine whether a self-funded group health plan has elected to participate in balance billing protections for their members.

3. An out-of-network provider or facility providing emergency services or nonemergency health care services at certain participating facilities (as defined in RCW 48.43.005) may submit this request if it is believed that the payment made for the covered services was not a commercially reasonable amount. A carrier or self-funded group health plan that has elected to participate in balance billing protections for its members may also submit a request for arbitration.

4. Upon OIC review and acceptance of a request for arbitration, both the initiating and non-initiating parties will be provided with a list of approved arbitrators and arbitration entities by OIC. If the parties cannot agree on an arbitrator or arbitration entity from the list, they must notify the OIC. The OIC will then contact the parties and follow the process outlined in RCW 48.49.040 and WAC 284-43B-035. Within 10 business days of the initiating party notifying the commissioner and the non-initiating party of intent to initiate arbitration, both parties must agree to and execute a nondisclosure agreement.

5. Once the arbitrator has been chosen, OIC will send the arbitrator/arbitration entity a copy of the Arbitration Initiation Request Form and both parties will have 30 calendar days to make written submissions to the arbitrator. A party that fails to make timely written submissions without good cause shown will be considered to be in default and will be ordered to pay the final offer amount submitted by the party not in default. The arbitrator may require the party in default to pay expenses incurred to date in the course of arbitration, including the arbitrator's expenses and fees and the reasonable attorneys' fees of the party not in default.

6. No later than 30 calendar days after the receipt of the parties' written submissions, the arbitrator will: Issue a written decision requiring payment of the final offer amount of either the initiating party or the non-initiating party, notify the parties of its decision, and provide the decision as well as the information described in RCW 48.49.050 regarding the decision to OIC. The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-085, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-085, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-090 Appendix B.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Please complete the form below and send it with the corresponding Arbitration Initiation Request Form and your decision to BBPA_Arbitration@oic.wa.gov

ARBITRATOR DECISION REPORTING FORM

1. ARBITRATOR'S INFORMATION

Your name and contact Information:

Date of decision:	**OIC Tracking Number:**

2. DISPUTE RESOLUTION INFORMATION This information is required under RCW 48.49.050

(a) Name of carrier:	**(b) Name of health care provider that directly provided the service:**
(c) Name and address of the health care provider's group practice, employer or business entity in which provider has ownership interest:	**(d) Name and address of the health care facility where services were provided:**

(e) Type of health care services at issue:

(f) Which parties' final offer was chosen: ***(Report separately bundled claims)***

The arbitrator reporting statutory provision is noted on the following page.

ARBITRATOR DECISION REPORTING PROVISION

RCW 48.49.040

Dispute resolution process—Determination of commercially reasonable payment amount. *(Effective March 31, 2022)*

(8)(a) No later than thirty calendar days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the initiating party or the noninitiating party; notify the parties of its decision; and provide the decision and the information described in RCW 48.49.050 regarding the decision to the commissioner. The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-090, filed 12/19/22, effective 1/19/23. Statutory Authority: RCW 48.49.060 and 48.49.110. WSR 20-22-076, § 284-43B-090, filed 11/2/20, effective 12/3/20.]

WAC 284-43B-095 Appendix C.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Please complete the form below and send it with the corresponding Arbitration Initiation Request Form and your decision to BBPA_Arbitration@oic.wa.gov

ARBITRATOR DECISION REPORTING FORM FOR ARBITRATION PROCEEDINGS UNDER RCW 48.49.135	
1. ARBITRATOR'S INFORMATION	
Your name and contact Information:	
Date of decision:	**OIC Tracking Number:**
2. DISPUTE RESOLUTION INFORMATION This information is required under RCW 48.49.050 & RCW 48.49.040	
(a) Date Amended AADR was approved by OIC:	**(b) Name of carrier:**
(c) Name of facility, provider(s) or provider group(s):	**(d) Applicable counties:**
(e) Service(s) at issue:	
(f) Which party's final offer was chosen:	
The arbitrator reporting statutory provision is noted on the following page.	

ARBITRATOR DECISION REPORTING PROVISION

RCW 48.49.040

Dispute resolution process—Determination of commercially reasonable payment amount. ***(Effective March 31, 2022)***

(8)(a) No later than thirty calendar days after the receipt of the parties' written submissions, the arbitrator must: Issue a written decision requiring payment of the final offer amount of either the initiating party or the noninitiating party; notify the parties of its decision; and provide the decision and the information described in RCW **48.49.050** regarding the decision to the commissioner. The arbitrator's decision must include an explanation of the elements of the parties' submissions the arbitrator relied upon to make their decision and why those elements were relevant to their decision.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-095, filed 12/19/22, effective 1/19/23.]

WAC 284-43B-100 Appendix D.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Please complete the form below and send it with the corresponding Arbitration Initiation Request Form and your decision to BBPA_Arbitration@oic.wa.gov

SETTLEMENT REPORTING FORM

1. INITIATING PARTY INFORMATION	
Your name and contact Information:	
Date of settlement:	**OIC Tracking Number:**
2. DISPUTE RESOLUTION INFORMATION This information is required under RCW 48.49.050	
(a) Name of carrier:	**(b) Name of health care provider that directly provided the service:**
(c) Name and address of the health care provider's group practice, employer or business entity in which provider has ownership interest:	**(d) Name and address of the health care facility where services were provided:**
(e) Type of health care services at issue:	
(f) Out-of-network rate for services:	
(g) Initiating party signature:	
(h) Responding party signature:	
The arbitrator reporting statutory provision is noted on the back of this form.	

SETTLEMENT REPORTING PROVISION

RCW 48.49.040

Dispute resolution process—Determination of commercially reasonable payment amount. *(Effective March 31, 2022)*

(7) If the parties agree on an out-of-network rate for the services at issue after providing the arbitration initiation notice to the commissioner but before the arbitrator has made their decision, the amount agreed to by the parties for the service will be treated as the out-of-network rate for the service. The initiating party must send a notification to the commissioner and to the arbitrator, as soon as possible, but no later than three business days after the date of the agreement. The notification must include the out-of-network rate for the service and signatures from authorized signatories for both parties.

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-43B-100, filed 12/19/22, effective 1/19/23.]