Washington State Medical Association
Physician Driven Patient Focused

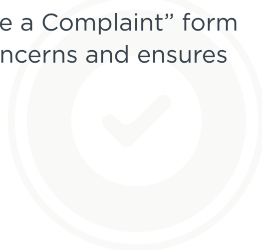
The WSMA Prior Authorization Navigator

Use the Navigator to access guidance on new rules regulating the prior authorization programs used by Washington insurers for medical services, and to file a complaint with the Office of the Insurance Commissioner when these programs are not operating according to the requirements.

HOW IT WORKS:

The Navigator is designed to be your partner and protector during prior authorization. Simply bookmark the website (priorauth.wsma.org) on your desktop, laptop or mobile device—you'll have the new requirements for medical services at your fingertips (we also include information on 2015 rules for prescription drugs). And you'll have access to a complaint form to message the OIC whenever you encounter an issue.

Why complain when you encounter a problem? Because the OIC's enforcement of its prior authorization rules rely upon a complaint-driven process. Your feedback via the WSMA Prior Authorization Navigator's "File a Complaint" form directly informs the OIC of concerns and ensures the rules' effectiveness.



Snapshot of key provisions:

Highlights of the new OIC rules for prior authorization of medical services.

ENFORCEMENT:

The OIC will use a complaint-driven process to enforce the rules.

TYPES AND TIMEFRAMES:

- **Standard request: Insurer must decide within five calendar days.**
- **Expedited request: Insurer must decide within two calendar days.**
- Extenuating circumstances: Insurers and their third-party administrators must have a provision for unforeseen situations.

THIRD-PARTY ADMINISTRATORS:

Insurers are obligated to ensure their third-party administrators comply with the rule's requirements.

CLINICAL REVIEW CRITERIA:

Criteria used by insurers or third-party administrators must be provided to physicians and facilities according to "patient-specific information for determination" (details at priorauth.wsma.org).

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COMMUNICATION:

- **The response to a prior authorization request must clearly state if the service is approved or denied. If denied, the response must give the specifics in clear and simple language.**
- **If denial is based on medical necessity, the clinical review criteria used to make the determination must be provided.**
- **A denial must include information on the enrollee's appeal rights in addition to inclusion of the department, credentials and phone number of the person denying the request.**

PRESCRIPTION DRUGS:

In late 2015, the OIC adopted rules aimed at improving prior authorization for prescription drugs. Find more information at priorauth.wsma.org.

TECHNOLOGY:

Starting Nov. 1, 2019, insurers and their third-party administrators are required to provide a secure, online process for participating physicians to complete a prior authorization request and upload required documentation.

Background:

The WSMA's initiative to address the causes of physician burnout—Healthy Doctors, Healthier Patients—specifically identified the demands of prior authorization as a source of physician frustration and burnout. Besides the exponentially increasing prior authorization requirements and constantly changing criteria, being forced to rely on outdated technology (fax machines, 800 numbers) exacerbated the torment.

To seek relief for physicians and practices, the WSMA, joined by the Washington State Hospital Association, met with the Office of the Insurance Commissioner to discuss prior authorization, its role as a driver of burnout and its impact on patient access to care.

As a result of WSMA's prolonged and extensive engagement, the OIC adopted a comprehensive set of regulations aimed at standardizing and streamlining the prior authorization processes used by insurers for medical services. The new rule puts sensible limits in place for the utilization management tool and marks a clear victory for the WSMA's HDHP initiative and patient access to care.

Most provisions of the new rules went into effect Jan. 1, 2018.

Covered Plans*

The rule applies to plans the OIC regulates:

- Individual (both on and off the Washington Health Benefit Exchange)
- Small group
- Large group (other than self-insured)

*The rule does not apply to Medicaid managed care organizations and Medicaid fee-for-service plans, Medicare, Taft-Hartley plans, PEBB/Uniform Medical and Tricare.

Visit the WSMA Prior Authorization Navigator at priorauth.wsma.org for complete details on the new rules, clarifications on existing laws and to access the complaint form.