ENGROSSED SUBSTITUTE SENATE BILL 6511

State of Washington 63rd Legislature 2014 Regular Session

By Senate Health Care (originally sponsored by Senators Becker and King)

READ FIRST TIME 02/07/14.

AN ACT Relating to prior authorization of health care services; and adding a new section to chapter 48.165 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.165 RCW to read as follows:

(1) The insurance commissioner must reauthorize the efforts with the lead organization established in RCW 48.165.030, and establish a new work group to develop recommendations for prior authorization requirements. The focus of the prior authorization efforts must include the full scope of health care services including pharmacy issues. The work group must submit recommendations to the commissioner by October 31, 2014.

(2) The lead organization and work group established to review prior authorization requirements must consider the following areas in their efforts:

(a) Requiring carriers and pharmacy benefit managers to provide a listing of prior authorization requirements electronically on a web site. The listing of requirements for any procedure, supply, or service requiring preauthorization must include criteria needed by the

carrier specific to that medical or procedural code, to allow a provider's office to submit all information needed on the initial request for prior authorization, along with instructions for submitting that information;

(b) Requiring a carrier or pharmacy benefit manager to issue an acknowledgement of receipt or reference number for prior authorization within a specified time frame, such as two business days of receipt of a prior authorization request from a provider;

(c) Recommendations for the best practices for exchanging information, including alternatives to fax requests;

(d) Recommendations for the best practices if the acknowledgement has not been received by the provider or pharmacy benefit manager within the specified time frame, such as two business days;

(e) Recommendations if the carrier or pharmacy benefit manager fails to approve, deny, or respond to the request for authorization within the specified time frame and options for deeming approval;

(f) Recommendations to refine the time frames in current rule;

(g) Recommendations to limit or eliminate the application of prior authorization to routine health care services for which a person may self-refer; and

(h) Recommendations specific to pharmacy services, including communication between the pharmacy to the carrier or pharmacy benefit manager, communications between the carrier or pharmacy benefit manager with the providers' office, communication of the authorization number, posting of the criteria for pharmacy related prior authorization on a web site and other recommended alternatives; and options for prior authorizations involving urgent and emergent care with short-term prescription fill, such as a three-day supply, while the authorization is obtained.

(3) In preparing the recommendations, the work group must consider the opportunities to align with national mandates and regulatory guidance in the health insurance portability and accountability act and the patient protection and affordable care act, and use information technologies and electronic health records to increase efficiencies in health care and reengineer and automate age-old practices to improve business functions and ensure timely access to care for patients.

(4) The commissioner must revise the rules for prior authorization

with the recommendations of the work group and only those recommendations.

--- END ---