

**RCW 71.24.618 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review.** (1) Beginning January 1, 2021, a managed care organization may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) Beginning January 1, 2021, a managed care organization must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b)(i) The managed care organization may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection.

(ii) Once the times specified in (a) of this subsection have passed, the managed care organization may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section. Beginning January 1, 2025, if a managed care organization authorizes inpatient or residential substance use disorder treatment services pursuant to (a)(i) of this subsection following the initial medical necessity review process under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the managed care organization approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization. Nothing prohibits a managed care organization from requesting information to assist with a seamless transfer under this subsection.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's managed care organization as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the managed care organization with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the managed care organization may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a managed care organization may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of

abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a managed care organization may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the managed care organization must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3) (a) The behavioral health agency shall document to the managed care organization the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(b) Beginning January 1, 2025, for inpatient or residential substance use disorder treatment services, the managed care organization may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The managed care organization is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the managed care organization involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the managed care organization shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The managed care organization shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the managed care organization's network is not available, the managed care organization shall pay the current agency at the service level until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically

monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. [2024 c 366 s 8; 2020 c 345 s 4.]

**Findings—Intent—2024 c 366:** See note following RCW 71.24.847.

**Findings—Intent—2020 c 345:** See note following RCW 41.05.526.