Issuer:

ANALYST CHECKLIST

SINGLE CASE PROVIDER AND FACILITY AGREEMENTS

Agreement Form Number:

General review requirements

Authority to Review Agreement –, RCW 48.43.730, RCW 48.39.003, & WAC 284-170-480

DO **NOT** MAKE ANY CHANGES TO THIS CHECKLIST. IF THE CHECKLIST IS NOT APPLICABLE, OR IF THE PROVIDER OR FACILITY AGREEMENT DOES NOT COMPLY WITH ALL PROVISIONS OF LAW STATED BELOW, PLEASE EXPLAIN:

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| **Administrative Policies** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.505WAC 284-170-421(5) | The agreement must describe the responsibilities of providers and facilities under the issuer's administrative policies and programs, including but not limited to:1. Payment terms;
2. Utilization review;
3. Quality assessment and improvement programs;
4. Credentialing;
5. Grievance, appeal, and adverse benefit determination procedures;
6. Data reporting requirements;
7. Pharmacy benefit substitution processes;
8. Confidentiality requirements; and
9. Any applicable federal or state requirements.

Generic statements and legal citations do not provide enough information. |  |

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| **Audit Guidelines** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-460 | 1. Provider and facility agreements may not grant the issuer access to health information unrelated to enrollees.
2. If the agreement grants the issuer access to medical records for audit purposes, the agreement must state that access is limited to information necessary to perform the audit.
3. The terms of any billing audit standards must be mutual: If the agreement allows the issuer to audit provider or facility billing records, then the provider or facility has the right to audit the issuer’s billing records.
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| **Chiropractor Services Payment Parity** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.190 | A health carrier may not pay a chiropractor less for a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code than it pays any other type of licensed provider for the same or substantially similar code, except that carriers may:1. Implement a quality improvement program to promote cost effective and clinically efficacious health care services;
2. Contract with providers to comply with network adequacy standards;
3. Pay in-network providers differently than out-of-network providers; and
4. Pay a chiropractor less than another provider for procedures or services under the same or a substantially similar code based upon differences in the cost of maintaining a practice or carrying

malpractice insurance, as recognized by a nationally accepted reimbursement methodology. |  |

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| **Clean Claims** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-431 | Provider and facility agreements must describe the standards for the prompt payment of clean claims. Generic statements and bare legal citations do not provide enough information.1. 95% of monthly clean claims must be paid within 30 days of receipt;
2. 95% of all claims must be paid or denied within 60 days;
3. 1% Interest per month must be paid on all non-denied and unpaid clean claims 61 days or older when issuer does not meet the standards; and
4. The definition of clean claim must be consistent with the WAC language.
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| *Pay and Pursue* |  |  |
| WAC 284-170-431WAC 284-51-215 | Provider and facility agreements should explain how the issuer administers coordination of benefits:1. Issuer must not unreasonably delay payment of a claim by reason of the application of COB.
2. Issuer must establish a time limit for payment of claims and may not unreasonably delay payment.
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| **Compensation Notification** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-421(6) | 1. Participating providers and facilities as defined by WAC 284-170- 130(23) must be given reasonable notice of not less than 60 days of changes that affect provider or facility compensation or that affect health care service delivery.
2. Provisions for changing the terms of the agreement must permit the provider or facility to terminate the agreement rather than serve under unacceptable terms. However, the provider or facility must provide at least 60 days written notice to the issuer before termination.
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| **Conducting Business in Licensed Name** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.05.190RCW 48.30.050RCW 48.44.040RCW 48.46.060 | Issuers conducting business in the State of Washington must do so under the name licensed. Provider and facility agreements filed with the OIC must clearly indicate the name of the issuer who is ultimately responsible for conditions identified in the agreement.1. All parties to the agreement must be disclosed.
2. The names of the parties should be used consistently throughout the agreement.

The issuer cannot use one agreement to bind the provider or facility to all of the entities in the issuer’s corporate organization. The issuer must ask the provider or facility to sign a separate agreement with each affiliate. |  |

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| **Content of Filing** | **Specific Issues** | **Location (Page/Section #) or comments** |
| *Confidentiality of Personal Information* |  |  |
| RCW 48.02.068RCW 42.56.400(26) | Single case agreements containing an enrollee’s personal information should be filed in a “not-for public” filing. All nonpublic personal health information obtained by, disclosed to, or in the custody of the commissioner is confidential and is not subject to public disclosure underChapter 42.56 RCW. |  |
| *Complete Filing Documents* |  |  |
| RCW 48.46.243(1)RCW 48.43.730WAC 284-170-480WAC 284-58-030 WAC 284-44A-050 WAC 284-46A-050 | All forms that are part of the agreement, including exhibits, payment schedules, regulatory appendix, etc., must be filed, in their entirety for review via SERFF. |  |
| *Disposition of Single Case Agreements* |  |  |

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| WAC 284-170-200(5) | Single case agreements filed in a “not-for public” filing may be deemed approved on date filed to ensure that the enrollee obtains the covered service from a provider or facility at no greater cost to the enrollee than if the service were obtained from network providers and facilities |  |
| *Template Filings* |  |  |
| RCW 48.43.730WAC 284-170-480(2) | 1. An issuer may file a single case agreement template with the OIC, which the issuer may use to contract with multiple providers or facilities. The template must be issued exactly as approved.
2. An issuer must submit changes to a template agreement to the OIC 30 days prior to use and include a redline.
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| *Issuer must maintain copies* |  |  |
| WAC 284-170-480(4) | The issuer must have access to all provider and facility agreements and provide copies to the OIC upon 20 days prior written notice from the commissioner. |  |
| *Selection Standards* |  |  |
| WAC 284-170-411(4) | An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner. |  |

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| **Contracting Outside Health Care Plan** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.085 | 1. The agreement may not contain any provisions that will constrain enrollees, directly or indirectly, from freely contracting for services outside the plan on terms and conditions they choose.
2. The agreement must not discourage the provider or facility from contracting outside of the plan for non-covered services.
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| **Contract Termination** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-421(9) & (10) | 1. Issuer and participating providers and facilities as defined by WAC 284-170-130(23) must provide at least a 60-day notice to each other before terminating the agreement without cause.
2. Whether the termination was for cause, or without cause, the issuer must make a good faith effort to notify enrollees in writing at least 30 days prior to termination or immediately for a termination for cause that results in less than 30 day notice to a provider or carrier to all enrollees who are patients seen on a regular basis by a specialist; by a provider for whom they have a standing referral; or by a primary care provider.
	1. The agreement does not need to contain the 30-day notice, but the agreement cannot contain conflicting language.
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| **Enrollee Coverage*****Non-discrimination*** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-421(11) | The agreement must instruct participating providers and facilities to furnish covered services to enrollees without regard to the enrollee's enrollment in the plan as a private purchaser or as a participant in the publicly financed programs of health care services. Providers and facilities should be notified, even if they do not participate in the publicly financed programs. No wording should differentiate care for a subscriber who purchases privately vs. one on a public program. |  |

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| **Enrollee Eligibility Notification** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.525WAC 284-170-421(1) & (2) WAC 284-43-3070(1)(b) | 1. The agreement must tell the provider or facility how to obtain eligibility and benefit information.
2. The agreement may not modify benefits, terms, or conditions contained in the health plan. In the event of a conflict between the agreement and the health plan, the benefits, terms, and conditions of the health plan must govern.
3. The agreement may not contain language for rescinding authorization and refusing payment even where treatment was pre-authorized.
4. The issuer must notify the provider of any adverse benefit determination that involves the pre-service denial of a treatment or procedure prescribed by the provider.
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| **Grievance Procedures** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.055WAC 284-170-421(13)WAC 284-170-440*Kruger Clinic Orthopaedics v. Regence BlueShield**T 06-03* | 1. The agreement must describe the issuer’s procedures for review and adjudication of complaints arising out of the agreement. A reference to the issuer’s policy and procedure manual does not provide enough information.
2. Dispute resolution process:
	1. Is there a formal process?
	2. Not less than 30 days to file a dispute.
	3. All likely disputes covered?
	4. Unfairly advantages issuer?
	5. Cannot exclude judicial remedies.
	6. Cannot require binding Arbitration.
	7. Billing disputes resolved within 60 days?
3. If the issuer fails to grant or reject a request for review within 30 days, the complaint can be considered “rejected” by the provider/facility and may be submitted to nonbinding mediation.
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| *Out of Network Payments: Balance Billing – When Prohibited* |  |  |
| RCW 48.49.030RCW 48.49.040 | 1. Carriers and out-of-network providers/facilities are required to negotiate in good faith to determine a commercially reasonable payment amount for services. Enrollees may not be held responsible for anything above their in-network cost share.
2. Carriers and out-of-network providers/facilities may pursue arbitration to determine a commercially reasonable payment amount as a dispute resolution process if good faith negotiations do not yield successful results.
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| **Hold Harmless & Insolvency** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-421(3) | Each provider and facility agreement must include the hold harmless and insolvency language as stated in the WAC. Providers and facilities must agree that:1. They will not bill the patient for services provided under the contract;
2. They will continue treatment;
3. The contract cannot modify the enrollee’s rights under the health plan;
4. They will not bill the enrollee where issuer denies payment due to a breach of the agreement;
5. The hold harmless requirement survives the agreement; and
6. Subcontractors must also agree to the hold harmless requirement.
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| *Liability of Participant* |  |  |
| RCW 48.44.020(4)(a) RCW 48.46.243(1) | 1. Are all agreements in writing and state that in the event of issuer failure to pay for services the enrollee will not be liable to the provider or facility for sums owed by the issuer?
2. Does the agreement require that this hold harmless provision survives the termination of the agreement?
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| *Payment Collection* |  |  |
| RCW 48.80.030(5) & (6)WAC 284-170-421(4) | Agreements must inform providers/facilities that it is a class C felony to collect payment from enrollees in violation of the agreement. |  |

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| **Indian Health Care Providers** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-310(5)(a) | Issuers are encouraged but not required to use the Indian Health Care Provider Addendum. If the issuer is using the addendum, is it the most current version of the:1. “Washington State Indian Health Care Provider Addendum”? <http://www.aihc-wa.com/>
2. “Model QHP Addendum for Indian Health Care Providers”? <https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf>
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| *25 USC 1621(a)**Section 206(a) and (e)* | Does the addendum or agreement contain provision(s) that conflict with federal reimbursement requirements? |  |

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| **Mental/Behavioral Health Providers** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.087(2)RCW 48.43.087(3) | 1. No contracts between a mental health care practitioner (also known as a behavioral health provider) and an intermediary, or health carrier, may contain language preventing the practitioner and enrollee from agreeing to have services provided at the enrollees expense:
	* when the enrollee’s mental health care coverage is exhausted,
	* during an appeal or adverse certification process,
	* when an enrollee’s condition is excluded from coverage,
	* or, for any other clinically appropriate reason at any time.
2. If a mental health practitioner provides services to an enrollee during an appeal or adverse certification process, the practitioner must provide written notification to the enrollee that payment for services is the enrollee’s responsibility, unless the carrier elects to pay.
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| **Network Access** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-200(7)WAC 284-170-210 (3) | A single case provider agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.**The practice of entering into a single case provider reimbursement agreement is not an alternate access delivery system for purposes of establishing an adequate provider network.** |  |
| WAC 284-170-200(5) | Whenever the issuer has an absence of or an insufficient number or type of network providers or facilities to provide a particular covered health care service, the issuer must ensure that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. |  |

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| **Non-covered Services*****Dental Services*** | **Specific Issues** | **Location (Page/Section #) or comments** |
|  | Does the agreement contain language directly or indirectly prohibiting a |  |
|  | participating dental provider from offering or providing a subscriber non- |
|  | covered dental services on any terms or conditions acceptable to the |
| RCW 48.20.417RCW 48.21.147RCW 48.44.495 | dentist and the enrolled participant?Does the agreement contain language directly or indirectly requiring a participating dentist to provide services to an enrolled participant for a fee set by, or subject to the approval of the carrier for non-covered services, |
|  | including services that would be reimbursable under an enrollee’s |
|  | coverage outside of contractual limitations such as benefit maximums, |
|  | deductibles, coinsurance, waiting periods, or frequency limitations? |

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| **Non-covered Services*****Health Care Services*** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.016(5) | Provider agreements may not require a provider to provide a discount from usual and customary rates for health care services not covered under a health plan, policy, or other agreement, to which the provider is a party. |  |

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| **Overpayment Recovery***Issuer Requirement* | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.600 | Provider agreements must explain the issuer’s procedures for overpayment recovery. Generic statements and legal citations do not provide enough information.1. Except in the case of fraud, an issuer may not request a refund from a **health care provider** of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date payment was made. The time period must be reciprocal.
2. In the case of COB, the issuer must request a refund from a health care provider of payment previously made to satisfy a claim within 30 months after the date payment was made.
3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made.
4. Not applicable to subrogation claims.
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| *“HealthCare Provider” or “Provider” Requirement* |  |  |
| RCW 48.43.005RCW 48.43.605 | 1. Except in the case of fraud, a **health care provider** may not request payment from the issuer to satisfy a claim unless it does so in writing to the issuer within 24 months after the date the claim was denied or payment intended to satisfy the claim was made.
2. In the case of COB, the provider must request from the issuer within 30 months after original payment was made any additional balances owed.
3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made.
4. Not applicable to subrogation claims.
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| **Opiate Overdose Reversal Rx** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 70.41.480RCW 70.41.485RCW 71.24.594RCW 48.43.762 | 1. Hospital agreements may not prohibit practitioners from prescribing pre-packaged emergency medications as outlined in RCW 70.41.480.
2. A medical service agreement for a behavioral health provider must not include language that would restrict the provider from prescribing opiate overdose reversal medication, using their clinical & professional judgment. [71.24 RCW]
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| **Pharmacy Audit** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.200.220 | An entity that audits pharmacy claims or contracts with another entity to audit such claims:1. Must have a written appeals procedure and notify the pharmacy about the appeals procedure before conducting an audit;
2. May not audit a claim more than 24 months after adjudication;
3. Must notify the pharmacy 15 days before an on-site audit at the pharmacy or its corporate headquarters;
4. May not conduct an on-site audit during the first five days of any month without the pharmacy’s consent;
5. Must consult with a licensed pharmacist if the audit involves clinical or professional judgment;
6. May not conduct an on-site audit of more than 250 unique prescriptions within 12 months except in cases of alleged fraud;
7. May not conduct an on-site audit more than once every 12 months;
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| **Pharmacy Audit** | **Specific Issues** | **Location (Page/Section #) or comments** |
|  | 1. Must audit similar pharmacies under the same standards and parameters;
2. Must pay outstanding claims within 45 days after the earlier of the date all appeals are concluded or the date a final report is issued;
3. May not add dispensing fees or interest to any overpayment amounts unless the overpaid claim was for an incorrectly filled prescription;
4. May not recoup costs for clerical errors or other errors that did not result in financial harm to a consumer; and
5. May not charge a pharmacy for denied or disputed claims until the audit and appeals procedures are final.
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| RCW 48.200.230 | An entity must find that a pharmacy claim was incorrectly presented or paid based on identified transactions and not based on probability sampling, extrapolation, or other projections. |  |

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| **Pharmacy Emergency Fill Disclosure** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-470(7) | Every pharmacy provider or facility agreement must disclose that the issuer will authorize an emergency fill by the dispensing pharmacist and approve a claim for payment for the emergency fill when:1. the dispensing pharmacy cannot reach the issuer’s prior authorization department by phone due the call being placed outside of the department’s business hours; or
2. the issuer is available by phone, but the issuer cannot reach the prescriber for full consultation.

The definition of “emergency fill” must be consistent with the WAC. |  |

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| **Pharmacy Preauthorization Disclosure** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-470(5) | Every pharmacy provider or facility agreement must disclose:1. whether the provider or pharmacy has the right to request preauthorization; and
2. that if the issuer requires the authorization number to appear on a pharmaceutical claim, the issuer will provide the number to the billing pharmacy after approval of the preauthorization request and upon receipt of a claim for that authorized medication.
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| **Prescription Drug Utilization** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.400RCW 48.43.410RCW 48.43.420(1)RCW 48.43.420(8)RCW 48.43.420(9) | 1. Definitions described in RCW 48.43.400 are specific to terms used in RCW 48.43.410 and RCW 48.43.420
2. Every provider contract for a prescribing practitioner must provide access to a clear, readily accessible, and convenient process to request an exception to the drug utilization management process. The agreement can direct the provider to the carrier’s website for further information.
3. The health carrier or prescription drug utilization management entity must permit a stabilized patient to remain on a drug during an exception request process.
4. A health carrier must provide 60 days’ notice to providers and patients for any new policies or procedures applicable to prescription drug utilization management protocols. New health carrier policies or procedures may not be applied retroactively.
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| **Postpartum Contraception** | **Specific Issues** | **Location (Page/Section #) or comments** |
| *HB1651* | **Effective January 1, 2023:** Provider and facility compensation exhibits may not contain language requiring a provider to only bill using the maternity global billing allowance for postpartum contraception. |  |

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| **Prescription Drug Affordability** | **Specific Issues** | **Location (Page/Section #) or comments** |
| *2SSB5532* | Currently pending Rulemaking |  |

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| **Prior Authorization** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.016(1)RCW 48.43.016(2)RCW 48.43.016(6)RCW 48.43.016(7) | 1. If the agreement imposes different prior authorization standards and criteria for a covered service among tiers of contracting providers of the same licensed profession in the same health plan, the carrier must inform the enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.
2. The agreement cannot require utilization management or review of any kind for an initial evaluation and management visit, and up to six treatment visits with a contracting provider in a new episode of care for each of the following:
	* Chiropractic
	* Physical therapy
	* Occupational therapy
	* Acupuncture and Eastern medicine
	* Massage therapy
	* Speech and hearing therapies

Visits where utilization management or review is prohibited are still subject to quantitative treatment limits of the health plan. With the exception of RCW 48.43.515(5) for chiropractors, the health plan can require a referral or prescription for the therapies listed.1. For visits where utilization management or review is prohibited, a health carrier or its contracted entity may not:
2. Deny or limit coverage on the basis of medical necessity or appropriateness; or
3. Retroactively deny care or refuse payment for the visits.

4. A health carrier can deny coverage based on insurance fraud. |  |
| *Prior Authorization Process* |  |  |
| WAC 284-170-421(5)WAC 284-43-2050 | 1. Does the contract require the issuer to give the provider 60 day notice before the issuer makes changes to its prior authorization program, including adding new prior authorization requirements to services or changing the clinical criteria used to approve prior authorization?
2. Does the contract include the method the issuer uses to accept prior authorization requests and the method for the provider to appeal a prior authorization denial?
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| **Prior Authorization** | **Specific Issues** | **Location (Page/Section #) or comments** |
|  | 3. Does the contract advise the provider that information relating to the prior authorization process can be found via a secure online process? **NOTE: This provision does not apply to employees of a carrier with an integrated delivery system.** |  |

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| **Protection of Individual Right to Privacy & Confidential Services** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.505 | 1. The health carrier may not require protected individuals to obtain permission from the policyholder, subscriber, or another covered person to receive care or submit a claim if they have the right to consent to care.
2. The health carrier must recognize the right of a protected individual or enrollee to exercise their rights regarding health information related to care they’ve received
3. The health carrier must direct all communications regarding a protected individual’s receipt of sensitive health services to the patient receiving care, or via postal mail, e-mail, or telephone number specified by the protected individual. Carriers may not disclose information to anyone other than the protected individual without their written, or recorded verbal consent.
4. A protected individual may request communications regarding the receipt of sensitive health care services be sent to another individual or provider for the purposes of appealing adverse benefit determinations.
5. The health carrier will limit disclosure of any information about a protected individual who is the subject of the information and will direct communications directly to the protected individual, or via mail, e-mail, or phone number specified by the protected individual upon request.
6. The health carrier may not require a protected individual to waive any right to limit disclosure as a condition of eligibility or coverage.
7. To protect patient confidentiality, any communication from a carrier relating to care – if the communications disclose protected health information, information relating to sensitive services – must be provided in the form & format requested by the patient receiving care.
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| **Provider/Patient Care** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.510(6)RCW 48.43.510(7)WAC 284-170-421(7)(a) & (b) | Each provider and facility agreement must include the language from the WAC allowing providers to inform patients about care and issuer merits. |  |

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| **Provider Manual****(Should Not Be Incorporated in Agreement)** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.055WAC 284-170-411(4)WAC 284-170-421WAC 284-170-480(4) | 1. The entire provider or facility agreement must be filed for review.
2. Please do not reference the provider manual in the agreement.
3. If the provider or facility agreement references or incorporates by reference additional documents, administrative manuals, or procedures, such documents, manuals, and procedures must be submitted to the OIC for approval.
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| **Record Retention** | **Specific Issues** | **Location (Page/Section #) or comments** |
| WAC 284-170-421(8) | Issuer must require providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees subject to applicable state and federal laws related to confidentiality of medical or health records. |  |

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| **Signature Block** | **Specific Issues** | **Location (Page/Section #) or comments** |
| Federal E-Sign Act | Acceptable formats include:* The electronically signed contract signature page attached to the provider agreement
* If a copy of the electronic signature page cannot be produced, a statement must be placed in the General Information tab of the SERFF filing advising the agreement was electronically signed and done so in a manner that complies with the Federal E-Sign Act.
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| **Standard of Care** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.545 | 1. Issuer may not unfairly transfer liability.
2. Are Indemnity/liability clauses consistent with the responsibility/right to determine when treatment is medically necessary?
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| **Telemedicine Payment Parity** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.735WAC 284-170-433 | 1. Telemedicine **includes** use of interactive audio and video technology. This includes **audio-only** telemedicine but excludes fax or e-mail.
2. The agreement must compensate providers for telemedicine services at the same amount of compensation the carrier would have paid the provider for in-person services.
3. The carrier can negotiate a telemedicine amount of compensation that differs from in-person services for:
	* hospitals,
	* hospital systems,
	* telemedicine companies, and
	* provider groups consisting of 11 or more providers.
4. The carrier can negotiate payment of facility fees for telemedicine services that originate at:
	* a hospital,
	* a rural health clinic,
	* a Federally qualified health center,
	* a physician/health care provider’s office,
	* licensed or certified behavioral health agency,
	* skilled nursing facility,
	* home or any location determined by the individual receiving the service, or
	* a renal dialysis center (except an internal renal dialysis center).
5. Any other sites **may not** charge a facility fee.
6. The carrier may not distinguish between originating sites that are rural and urban when providing coverage.
7. The carrier is not required to reimburse:
	* an originating site for professional fees,
	* services not covered under the plan, or
	* an originating site or provider that is not contracted under the plan.
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| **Telemedicine Payment Parity** | **Specific Issues** | **Location (Page/Section #) or comments** |
|  | 8. The agreement must notify providers that audio-only telemedicine billing requires advance consent from the patient. Failure to obtain patient consent could result in disciplinary action against the provider.**Effective 1/1/2023:** The provider must have an established relationship with the patient to bill for audio-only telemedicine. |  |

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| **Utilization Review** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.520RCW 48.43.525WAC 284-43-2000 | 1. The agreement must tell the provider or facility how to obtain preauthorization.
2. Issuer may not retrospectively deny coverage for emergency or non- emergency care that was preauthorized.
3. Retrospective review decisions are based solely on the medical information available to the attending physician at time the health services were provided.
4. Retrospective review determinations must be completed within 30 days of receipt of the necessary information.
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| **Withdrawal Management Services** | **Specific Issues** | **Location (Page/Section #) or comments** |
| RCW 48.43.761WAC 284-43-2000 | 1. The contract cannot specify timeframes for substance abuse disorder treatment less than what is specified in RCW 48.43.761(2)(a)(i)
2. The contract cannot specify timeframes for withdrawal management services less than what is specified in RCW 48.43.761(2)(a)(ii)
3. The contract cannot contain language that prevents a seamless transfer to an appropriate level of care.
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