# ESSB 6404 Data Reporting Instruction Sheet

**June 18, 2020**

**For 2020 Data Submission (based on CY 2019 data)**

**Responses should be submitted to OIC at**: [market.conduct@oic.wa.gov](mailto:market.conduct@oic.wa.gov)

Sec. 1(1) of ESSB 6404 identifies the carriers required to report prior authorization data based upon a threshold percentage of premiums written in Washington state. In interpreting this language, OIC took into consideration the codification of ESSB 6404 in chapter 48.43 RCW, which relates to regulation of health plans, and consistency with existing National Association of Insurance Commissioner (NAIC) carrier financial reporting requirements. OIC has calculated the 1% threshold based upon premiums written in the individual, student health plan, small group and large group markets during 2019 as reported to NAIC in the Supplemental Health Care Exhibit. The following carriers meet the 1% threshold for CY 2019:

* Premera Blue Cross
* LifeWise Health Plan of WA
* Regence BlueShield
* Regence BCBS of Oregon
* Asuris NW Health
* Kaiser Fdn,. Health Plan of WA
* Kaiser Fdn. Health Plan of WA Options
* Kaiser Fdn. Health Plan of the Northwest
* Aetna Life Insurance Company
* Coordinated Care Corp.
* Molina HealthCare of WA
* UnitedHealthCare Insurance Co.
* UnitedHealthCare of WA Inc.

By October 1, 2020, for Washington state residents enrolled in commercial health plans issued in Washington state, the carriers listed above must report the de-identified and aggregated data listed below to the Insurance Commissioner for calendar year 2019 using the Excel workbook accompanying these instructions.

To ensure that the October 1, 2020 reporting deadline is met, **carriers are strongly encouraged to submit their data by September 1, 2020**. This will provide OIC the opportunity to review each carrier’s initial submission and ensure that it is in compliance with the requirements of the law prior to the October 1 statutory deadline.

The data to be reported is as follows:

* The ten inpatient medical or surgical codes, ten outpatient medical or surgical codes, ten inpatient mental health and substance use disorder codes, ten outpatient mental health and substance use disorder codes**,**  ten diabetes supplies and equipment codes, and ten durable medical equipment codes with:
  + The highest total number of prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code;
  + The highest percentage of approved prior authorization requests during the previous plan year, including the total number of requests and percent of approved requests for each code. If more than ten codes have an approval rate of 100%, the carrier should default to those codes with the greatest number of prior authorization requests;
  + The highest percentage of prior authorization requests that were initially denied, appealed by an enrollee and then subsequently approved on appeal, counting internal and external appeals, including the total number of requests and the percent of requests initially denied and then subsequently approved for each code; and
* the average determination response time in hours for prior authorization requests to the plan with respect to each covered service included in the lists above for each of the following categories:
  + expedited decisions;
  + standard decisions; and
  + extenuating circumstances decisions. OIC assumes that per WAC 284-43-2060, priorauthorization will not have occurred for these claims. Under WAC 284-43-2060(6), claims and appeals related to an extenuating circumstance may still be reviewed for appropriateness, level of care, effectiveness, benefit coverage and medical necessity under the criteria for the applicable plan, based on the information available to the provider or facility at the time of treatment. For claims processed via extenuating circumstances, the carrier should report the average response time in which authorization occurred following notification to the carrier by the provider or claim submission. In its reporting, a carrier may distinguish between claims for which a provider has notified the carrier of an extenuating circumstance prior to claims submission, and those claims that are administratively denied because a provider did not report the extenuating circumstances prior to claim submission and are then disputed by the provider.

ESSB 6404 requires reporting of response time in hours. A carrier whose data system does not track time in hours, but rather days, may use 8 hours if the approval occurs within one day, but should report a day as 24 hours if there are multiple days involved.

Attached is an Excel workbook for the carrier to enter its data. Each service category has a tab with a labelled worksheet that contains three (3) tables. The tables correspond with the requirements above. The top ten (10) codes entered into each **table are to be unique to each question asked in Column B**. For each code or codes (if the same service can be billed using more than one type of code) reported, provide a description of the service to which the code applies. Please report data for calendar year 2019, based upon the date of service.

Definitions:

* Codes - For purposes of this report, codes include CPT, HCPC and revenue codes. If the same service can be paid using more than one type of code, e.g. both a HCPC and a revenue code, then prior authorization requests using either code should be combined in calculating the number of prior authorization requests. However, if a CPT or HCPC code applies to both medical/surgical and mental health/substance use disorder diagnoses, the volume of prior authorization requests for the service should be calculated separately for medical/surgical diagnoses and for mental health/substance use disorder diagnoses to determine whether that code constitutes one of the top ten codes for either medical/surgical or mental health/substance use disorder services. “Unlisted codes”, which are used when there is not CPT or HCPC code that accurately identifies the surgery or procedure being performed, should not be considered “codes” for purposes of reporting.
* Diabetes Supplies & Equipment – Materials and equipment used to assist in the monitoring of diabetes, including but not limited to blood sugar (glucose) test strips, blood glucose monitors, lancet devices, lancets, and glucose control solutions for checking the accuracy of test strips and monitors.
* Durable Medical Equipment - Durable medical equipment is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. As defined in [RCW 48.43.290](https://inside.oic.wa.gov/oic-templates-and-logos), the [HealthCare.gov glossary](https://inside.oic.wa.gov/oic-templates-and-logos) and for [Medicare coverage](https://inside.oic.wa.gov/oic-templates-and-logos), durable medical equipment does not include implantable devices, prosthetics or orthotics.
* Expedited Request Decisions - any request by a provider or facility for approval of a service where the passage of time could seriously jeopardize the life or health of the enrollee, seriously jeopardize the enrollee's ability to regain maximum function, or, in the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the service that is the subject of the request (See WAC 284-43-0160 and WAC 284-43-2050).
* Extenuating Circumstance - an extenuating circumstance means an unforeseen event or set of circumstances, which adversely affects the ability of a participating provider or facility to request prior authorization prior to service delivery (See WAC 284-43-2060).
* Prior Authorization – A mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. This includes any term used by a carrier or its designated or contracted representative to describe this process. Per the definitions of “prior authorization” and “authorization” in WAC 284-43-0160, prior authorization occurs before a service is delivered and does not include continued stay reviews.
* Standard Request Decisions - a request by a provider or facility for approval of a service where the request is made in advance of the enrollee obtaining a service that is not required to be expedited (See WAC 284-43-0160 and 284-43-2050).

For questions, please contact Ned Gaines at (360) 725-7216 or submit an e-mail to [market.conduct@oic.wa.gov](mailto:market.conduct@oic.wa.gov).