

ESB 5887 - H COMM AMD

By Committee on Health Care & Wellness

NOT ADOPTED 04/12/2019

1 Strike everything after the enacting clause and insert the
2 following:

3 "Sec. 1. RCW 48.43.016 and 2018 c 193 s 1 are each amended to
4 read as follows:

5 (1) A health carrier or its contracted entity that imposes
6 different prior authorization standards and criteria for a covered
7 service among tiers of contracting providers of the same licensed
8 profession in the same health plan shall inform an enrollee which
9 tier an individual provider or group of providers is in by posting
10 the information on its web site in a manner accessible to both
11 enrollees and providers.

12 (2) (a) A health carrier or its contracted entity may not require
13 prior authorization for an initial evaluation and management visit
14 and up to six ((consecutive)) treatment visits with a contracting
15 provider ((in a new episode of care of)) for each of the following:
16 Chiropractic, physical therapy, occupational therapy, East Asian
17 medicine, massage therapy, or speech and hearing therapies ((that
18 meet the standards of medical necessity and)). Visits for which prior
19 authorization is not required under this section are subject to
20 quantitative treatment limits of the health plan. Notwithstanding RCW
21 48.43.515(5) this section may not be interpreted to limit the ability
22 of a health plan to require a referral or prescription for the
23 therapies listed in this section.

24 (b) For visits for which prior authorization is not required
25 under this section, a health carrier or its contracted entity may
26 not:

27 (i) Deny or limit coverage on the basis of medical necessity or
28 appropriateness if the patient's treating or referring provider has
29 determined that the visits are medically necessary; or

30 (ii) Retroactively deny care or refuse payment for the visits.

1 (3) A health carrier shall post on its web site and provide upon
2 the request of a covered person or contracting provider any prior
3 authorization standards, criteria, or information the carrier uses
4 for medical necessity decisions.

5 (4) A health care provider with whom a health carrier consults
6 regarding a decision to deny, limit, or terminate a person's covered
7 health care services must hold a license, certification, or
8 registration, in good standing and must be in the same or related
9 health field as the health care provider being reviewed or of a
10 specialty whose practice entails the same or similar covered health
11 care service.

12 (5) A health carrier may not require a provider to provide a
13 discount from usual and customary rates for health care services not
14 covered under a health plan, policy, or other agreement, to which the
15 provider is a party.

16 (6) For purposes of this section((÷

17 ~~(a) "New episode of care" means treatment for a new or recurrent~~
18 ~~condition for which the enrollee has not been treated by the provider~~
19 ~~within the previous ninety days and is not currently undergoing any~~
20 ~~active treatment.~~

21 ~~(b))~~ l "contracting provider" does not include providers employed
22 within an integrated delivery system operated by a carrier licensed
23 under chapter 48.44 or 48.46 RCW."

24 Correct the title.

EFFECT: Makes provisions relating to prior authorization
applicable to a health carrier's contracting entity, in addition to
the carrier itself. Clarifies that prior authorization may not be
required for six visits for each of the following: Chiropractic,
physical therapy, occupational therapy, acupuncture, massage therapy,
or speech and hearing therapy. Removes the requirement that the six
visits be consecutive or for a new episode of care. Prohibits a
health carrier or its contracting entity from retroactively denying
care or refusing payment for the six visits.

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