

2ESB 5887 - H COMM AMD

By Committee on Health Care & Wellness

ADOPTED 03/03/2020

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

3 "NEW SECTION. **Sec. 1.** The legislature intends to facilitate
4 patient access to appropriate therapies for newly diagnosed health
5 conditions while recognizing the necessity for health carriers to
6 employ reasonable utilization management techniques.

7 **Sec. 2.** RCW 48.43.016 and 2019 c 308 s 22 are each amended to
8 read as follows:

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

16 (2) (a) A health carrier or its contracted entity may not require
17 utilization management or review of any kind including, but not
18 limited to, prior, concurrent, or postservice authorization for an
19 initial evaluation and management visit and up to six (~~consecutive~~)
20 treatment visits with a contracting provider in a new episode of care
21 (~~of chiropractic~~) for each of the following: Chiropractic, physical
22 therapy, occupational therapy, acupuncture and Eastern medicine,
23 massage therapy, or speech and hearing therapies (~~that meet the~~
24 ~~standards of medical necessity and~~). Visits for which utilization
25 management or review is prohibited under this section are subject to
26 quantitative treatment limits of the health plan. Notwithstanding RCW
27 48.43.515(5) this section may not be interpreted to limit the ability
28 of a health plan to require a referral or prescription for the
29 therapies listed in this section.

1 (b) For visits for which utilization management or review is
2 prohibited under this section, a health carrier or its contracted
3 entity may not:

4 (i) Deny or limit coverage on the basis of medical necessity or
5 appropriateness; or

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

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

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

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

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

24 (7) For purposes of this section:

25 (a) "New episode of care" means treatment for a new (~~or~~
26 ~~recurrent~~) condition or diagnosis for which the enrollee has not
27 been treated by (~~the~~) a provider of the same licensed profession
28 within the previous ninety days and is not currently undergoing any
29 active treatment.

30 (b) "Contracting provider" does not include providers employed
31 within an integrated delivery system operated by a carrier licensed
32 under chapter 48.44 or 48.46 RCW."

33 Correct the title.

EFFECT: Makes terminology consistent by changing "prior
authorization" to "utilization management or review."

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