Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

2ESB 5887

Brief Description: Concerning health carrier requirements for prior authorization standards.

Sponsors: Senators Short, Keiser and Nguyen.

Brief Summary of Second Engrossed Bill

- Changes prior authorization requirements applicable to health carriers.

Hearing Date: 2/12/20

Staff: Jim Morishima (786-7191).

Background:

Prior authorization is the requirement that a provider receive approval from a health carrier prior to performing a health care service for reimbursement. A health carrier that 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 must inform an enrollee which tier a provider is in by posting the information on its web site in a manner accessible to both enrollees and providers.

Additionally, a health carrier may not require prior authorization for an initial evaluation and management visit and up to six consecutive treatment visits in a new episode of care for the following types of services: chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy. The visits are subject to the carrier's medical necessity standards and are subject to any quantitative treatment limits of the health plan.

"New episode of care" is defined as treatment for a new or recurrent condition for which the enrollee has not been treated by the provider within the previous 90 days and is not currently undergoing any active treatment.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Summary of Bill:

The prohibition against prior authorization for chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy visits is expanded to prohibit any kind of utilization management or review, including prior, concurrent, or post-service authorization. The prohibition against utilization management or review applies to an initial evaluation and management visit and up to six treatment visits for each of chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy visits.

The medical necessity requirement is eliminated for the visits. Coverage for the visits may not be denied or limited on the basis of medical necessity or appropriateness. Care may not be retroactively denied and payment may not be retroactively refused for the visits. The requirement that the visits be consecutive is eliminated.

The definition of "new episode of care" is made applicable to new conditions or diagnoses, instead of new or recurrent conditions. The definition is expanded to include situations where an enrollee has been previously treated by a different licensed profession.

The requirements related to prior authorization tiers and chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapy visits are made applicable to a health carrier's contracted entity, in addition to the health carrier itself. The restrictions on utilization review do not prevent a health carrier from denying coverage based on insurance fraud.

Appropriation: None.

Fiscal Note: Requested on February 10, 2020.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.