HB 1471-S2.E - DIGEST

(DIGEST AS ENACTED)

Requires a health carrier, and a health plan offered to public employees and their covered dependents, that impose 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 to inform an enrollee which tier an individual provider or group of providers is in.

Prohibits a health carrier from requiring prior authorization for an evaluation and management visit or an initial treatment visit with a contracting provider in a new episode of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies.

Requires a health carrier and the state health care authority to post on their web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the carrier or the health plan uses for medical necessity decisions.