

ESB 5887 - H AMD 652

By Representative Cody

ADOPTED 04/12/2019

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 2018 c 193 s 1 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~~
21 ~~care of~~) for each of the following: Chiropractic, physical therapy,
22 occupational therapy, East Asian medicine, massage therapy, or speech
23 and hearing therapies (~~that meet the standards of medical necessity~~
24 ~~and~~). Visits for which prior authorization is prohibited under this
25 section are subject to quantitative treatment limits of the health
26 plan. Notwithstanding RCW 48.43.515(5) this section may not be
27 interpreted to limit the ability of a health plan to require a
28 referral or prescription for the therapies listed in this section.

29 (b) For visits for which prior authorization is prohibited under
30 this section, a health carrier or its contracted entity may not:

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

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

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

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

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

20 (6) For purposes of this section:

21 (a) "New episode of care" means treatment for a new (~~or~~
22 ~~recurrent~~) condition or diagnosis for which the enrollee has not
23 been treated by the provider within the (~~previous ninety days~~) plan
24 year and is not currently undergoing any active treatment.

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

28 Correct the title.

EFFECT: Makes provisions relating to prior authorization
applicable to a health carrier's contracting entity, in addition to
the carrier itself. Expands the prohibition against prior
authorization to include utilization management or review of any
kind, including prior, concurrent, or postservice review. Clarifies
that utilization management or review 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. Changes the definition of
"new episode of care" by making it applicable to new conditions or
diagnoses (instead of new or recurrent conditions) and lengthening
the time period within which the enrollee may not have been treated
for the new condition or diagnosis to within the plan year, instead
of within the previous ninety days. Prohibits a health carrier or its

contracting entity from retroactively denying care or refusing payment for the six visits. Inserts an intent section.

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