SECOND ENGROSSED SENATE BILL 5887

AS AMENDED BY THE HOUSE

Passed Legislature - 2020 Regular Session

State of Washington 66th Legislature 2019 Regular Session

By Senators Short, Keiser, and Nguyen

Read first time 02/11/19. Referred to Committee on Health & Long Term Care.

AN ACT Relating to health carrier requirements for prior authorization standards; amending RCW 48.43.016; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

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

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

(1) A health carrier or its contracted entity 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 shall inform an enrollee which tier an individual provider or group of providers is in by posting the information on its web site in a manner accessible to both enrollees and providers.

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an

initial evaluation and management visit and up to six ((~~consecutive~~)) treatment visits with a contracting provider in a new episode of care ((~~of chiropractic~~)) for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies ((~~that meet the standards of medical necessity and~~)). Visits for which utilization management or review is prohibited under this section are subject to quantitative treatment limits of the health plan. Notwithstanding RCW 48.43.515(5) this section may not be interpreted to limit the ability of a health plan to require a referral or prescription for the therapies listed in this section.

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

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

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

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

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

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

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

(7) For purposes of this section:

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

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

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