2SSB 5596 - H AMD TO APP COMM AMD (H-5952.1/08) **1478**
By Representative Cody

ADOPTED 3/06/2008

1 On page 1 of the striking amendment, strike all material after
2 line 2 and insert the following:
3
4 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
5 RCW to read as follows:
6 (1)(a) Except as provided in (b) of this subsection, a health
7 carrier may not develop and use a payment methodology that would
8 result in a payment to a chiropractor under a physical medicine and
9 rehabilitation payment or billing code or an evaluation and
10 management payment or billing code in an amount less than a payment
11 to a different provider licensed under Title 18 RCW who is being
12 paid under the same physical medicine and rehabilitation payment or
13 billing code or the same evaluation and management payment or
14 billing code. For payment methodologies that are developed and
15 used on or after January 1, 2009, it is presumed that payment or
16 billing codes that apply only to health care services provided by
17 chiropractors are not in compliance with this requirement unless
18 the carrier shows to the commissioner's satisfaction that the
19 payment or billing codes are used only to achieve the purposes
20 permitted under (b) of this subsection.
21 (b) This section does not affect a health carrier's:
22 (i) Implementation of a health care quality improvement program
23 to promote cost-effective and clinically efficacious health care
24 services, including but not limited to pay-for-performance payment
25 methodologies and other programs fairly applied to all health care
26 providers licensed under Title 18 RCW that are designed to promote
27 evidence-based and research-based practices; or
28 (ii) Health care provider contracting to comply with the
29 network adequacy standards of RCW 48.43.515 and the rules adopted
30 by the commissioner establishing network adequacy standards.
31 (c) This section does not, and may not be construed to:

(i) Require the payment of provider billings that do not meet the definition of a clean claim as set forth in rules adopted by the commissioner;

(ii) Require any health plan to include coverage of any condition; or

(iii) Expand the scope of practice for any health care provider.

(2) This section applies only to payment methodologies developed or used on or after January 1, 2009.

Sec. 2. RCW 41.05.017 and 2007 c 502 s 2 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, 70.02.900, section 1 of this act, and 48.43.083.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Beginning January 1, 2009, the commissioner shall require carriers to report such data as the commissioner may determine are necessary for an evaluation of the impact of section 1 of this act on the utilization and cost of health care services associated with physical medicine and rehabilitation payment or billing codes and evaluation and management payment or billing codes, and on the total cost of episodes of care for treatment associated with the use of these payment or billing codes.

(2) The data may include, but need not be limited to, the following:

(a) Data on the utilization of physical medicine and rehabilitation services and evaluation and management services associated with payment or billing codes for those services;

(b) Data related to changes in the distribution or mix of health care providers providing services under physical medicine and rehabilitation payment or billing codes and evaluation and management payment or billing codes;

1 (c) Data related to trends in carrier expenditures for services
2 associated with physical medicine and rehabilitation payment or
3 billing codes and evaluation and management payment or billing
4 codes; and

5 (d) Data related to trends in carrier expenditures for the
6 total cost of health plan enrollee care for treatment of the
7 presenting health problems associated with the use of physical
8 medicine and rehabilitation payment or billing codes and evaluation
9 and management payment or billing codes.

10 (3) The commissioner may adopt rules necessary to implement
11 this section, including but not limited to the format and timing of
12 data reporting and defining the years for which data must be
13 provided.

14 (4)(a) Data, information, and documents provided by the carrier
15 pursuant to this section are exempt from public inspection and
16 copying under chapter 42.56 RCW to the extent that they contain
17 actuarial formulas, statistics, and assumptions submitted in
18 support of setting rates for the carrier's health plans.

19 (b) The commissioner is authorized to use documents, materials,
20 or other information obtained pursuant to this section in the
21 furtherance of any regulatory activities, reports to the
22 legislature, or legal actions brought as a part of the
23 commissioner's official duties.

24 (5) The commissioner shall submit the evaluation required in
25 subsection (1) of this section to the appropriate committees of the
26 senate and house of representatives by January 1, 2012.

27 NEW SECTION. **Sec. 4.** This act expires June 30, 2013."

28 Correct the title.

EFFECT: The amendment:

(1) adds that a health carrier may not use payment methodologies that pay a chiropractor less than a different provider using the same evaluation and management billing codes, as well as the same physical medicine and rehabilitation billing codes;

(2) removes language that allows health carriers, in determining payments to chiropractors as compared to

other providers, to use payment differentials that address the cost of a provider's practice, medical malpractice costs, or differences in training requirements or scope of practice;

(3) adds authority for the Insurance Commissioner, beginning January 1, 2009, to obtain data from health carriers to evaluate the impact of the chiropractor payment requirements on the utilization and cost of health care services associated with the physical medicine and rehabilitation billing codes and the evaluation and management codes;

(4) requires the Insurance Commissioner to report on the evaluation to the Legislature by January 1, 2012;

(5) deletes the null and void clause that would make the bill contingent on funding in the budget; and

(6) adds a June 30, 2013, expiration date for the bill.