



2023 ASSEMBLY BILL 507

October 18, 2023 - Introduced by Representatives VANDERMEER, GUSTAFSON, BILLINGS, BRANDTJEN, BROOKS, DONOVAN, GUNDRUM, MACCO, MAGNAFICI, MAXEY, RETTINGER, ROZAR, SCHMIDT, SHANKLAND, WICHGERS, WITTKE and MELOTIK, cosponsored by Senators TESTIN, BALLWEG, COWLES, L. JOHNSON, LARSON and NASS. Referred to Committee on Health, Aging and Long-Term Care.

AN ACT *to amend* 632.85 (title) and 632.85 (3); and *to create* 632.85 (1) (d) and 632.851 of the statutes; **relating to:** prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, and other services under health plans.

Analysis by the Legislative Reference Bureau

Generally, this bill requires and prohibits certain actions related to prior authorization of physical therapy, occupational therapy, speech therapy, chiropractic services, and other health care services by certain health plans. Under the bill, every health plan, when requested to reauthorize coverage, must issue a decision on reauthorization of coverage of a service for which prior authorization was previously obtained within 48 hours or prior authorization is assumed to be granted. Health plans are prohibited under the bill from requiring prior authorization for the first 12 physical therapy, occupational therapy, speech therapy, or chiropractic visits with no duration of care limitation or for any nonpharmacologic management of pain provided to individuals with chronic pain for the first 90 days of treatment. The bill requires plans to reference the applicable policy and include an explanation to the service provider and to the covered individual for any denial of coverage for or reduction in covered services. Further, the bill requires plans to compensate providers of physical therapy services,

ASSEMBLY BILL 507**SECTION 1**

occupational therapy services, speech therapy services, or chiropractic services as specified under the bill for data entry of clinical information that is required by a utilization review organization or utilization management organization acting on behalf of a plan. A plan must also impose copayment and coinsurance amounts on covered individuals for provided services that are equivalent to copayment and coinsurance amounts imposed for primary care services under the plan.

The bill also requires every utilization review organization and utilization management organization that is providing review or management on behalf of a health plan to provide to any licensed health care provider, upon request, all medical evidence-based policy information that accompanies the algorithms that are used to manage coverage and to operate and staff peer review activities with Wisconsin-licensed health care providers holding credentials for the type of service that is the subject of the review. The bill prohibits utilization review organizations and utilization management organizations from using claims data as evidence of outcomes for purposes of developing an algorithm to manage coverage or an approval policy for coverage. Health plans to which the above requirements and prohibitions apply are private health benefit plans and self-insured governmental health plans.

Additionally, the bill prohibits health care plans and self-insured governmental health plans from requiring prior authorization for coverage of any covered health care service that is incidental to a covered surgical service and determined by the covered person's physician or other health care provider to be medically necessary and of any covered urgent health care service as defined in the bill. Current law prohibits health care plans and self-insured governmental health plans from requiring prior authorization for coverage of emergency medical services.

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 632.85 (title) of the statutes is amended to read:

632.85 (title) Coverage without prior authorization for treatment of an emergency medical condition; other conditions.

SECTION 2. 632.85 (1) (d) of the statutes is created to read:

632.85 (1) (d) "Urgent health care service" means a health care service for which the application of the time for making a nonexpedited request for prior

ASSEMBLY BILL 507**SECTION 2**

authorization, in the opinion of a physician or other health care provider with knowledge of the covered person's medical condition, could do any of the following:

1. Seriously jeopardize the life or health of the covered person or the ability of that person to regain maximum function.

2. Subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

SECTION 3. 632.85 (3) of the statutes is amended to read:

632.85 (3) A health care plan or a self-insured health plan that is required to provide the coverage under sub. (2) may not require prior authorization for the provision or coverage of the emergency medical services specified in sub. (2), any covered health care service that is incidental to a covered surgical service and determined by the covered person's physician or other health care provider to be medically necessary, or any covered health care service that is an urgent health care service.

SECTION 4. 632.851 of the statutes is created to read:

632.851 Prior authorization; general; physical, occupational, speech therapy and chiropractic care. (1) In this section:

(a) "Episode of care" means treatment for a new or recurring condition for which an insured has not been treated within the previous 90 days.

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

(c) "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

ASSEMBLY BILL 507**SECTION 4**

(2) A health benefit plan or self-insured health plan that uses prior authorization procedures may not do any of the following:

(a) Require prior authorization for the first 12 physical therapy, occupational therapy, speech therapy, or chiropractic visits with no duration of care limitation. A plan may require prior authorization for visits after the initial 12 physical therapy, occupational therapy, speech therapy, or chiropractic visits of an episode of care for a specific condition.

(b) Require prior authorization for any nonpharmacologic management of pain provided to individuals with chronic pain for the first 90 days of treatment.

(3) A health benefit plan or self-insured health plan that provides coverage of physical therapy services, occupational therapy services, speech therapy services, or chiropractic services shall do all of the following with respect to such services:

(a) Reference the applicable policy and include an explanation to the service provider and, in plain language, to the covered individual for any denial of coverage or reduction in covered services.

(b) Compensate providers of physical therapy services, occupational therapy services, speech therapy services, or chiropractic services at 50 percent of the current procedure terminology therapeutic exercise rate for a therapeutic physical therapy procedure on one or more areas each lasting 15 minutes for each quarter hour of data entry of clinical information that is required by a utilization review organization or utilization management organization acting on behalf of a plan. The physical therapy service provider, occupational therapy service provider, speech therapy service provider, or chiropractic service provider shall invoice the

ASSEMBLY BILL 507**SECTION 4**

utilization review organization or utilization management organization monthly to obtain the compensation described under this paragraph or the health benefit plan or self-insured health plan shall increase reimbursement to physical therapy service providers, occupational therapy service provider, speech therapy service provider, or chiropractic service providers commensurate with increased administrative expenses.

(c) Impose copayment and coinsurance amounts on covered individuals for the services that are equivalent to copayment and coinsurance amounts imposed on covered individuals for primary care services under the plan.

(4) Every health benefit plan or self-insured health plan when requested to reauthorize coverage of a service for which prior authorization was previously obtained shall issue the decision on reauthorization within 48 hours of the request. If a plan does not issue a decision on reauthorization described under this subsection within 48 hours, prior authorization is assumed to be granted for the service.

(5) Every utilization review organization and utilization management organization that is providing review or management on behalf of a health benefit plan or self-insured health plan shall do all of the following:

(a) Provide to any licensed health care provider upon request all medical evidence-based policy information that accompanies the algorithms that are used to manage coverage. A utilization review organization or utilization management organization may not use claims data as evidence of outcomes for purposes of developing an algorithm to manage coverage or an approval policy for coverage.

ASSEMBLY BILL 507**SECTION 4**

(b) Operate and staff peer review activities with health care providers that are licensed in this state and hold credentials for the type of service that is the subject of the review.

(END)