SECOND REGULAR SESSION

SENATE BILL NO. 947

101ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR WHITE.

4302S.01I ADRIANE D. CROUSE, Secretary

AN ACT

To amend chapter 376, RSMo, by adding thereto eight new sections relating to prior authorization of health care services.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto eight new sections, to be known as sections 376.2100, 376.2102, 376.2104, 376.2106, 376.2108, 376.2110, 376.2112, and 376.2114, to read as follows:

376.2100. 1. As used in sections 376.2102 to 376.2114, terms shall have the same meanings as are ascribed to them in section 376.1350.

2. As used in sections 376.2102 to 376.2114, the term "prior authorization provider exemption" or "exemption" shall mean an exemption to a health benefit plan's prior authorization requirements for a health care provider for a particular health care service in accordance with sections 376.2102 to 376.2114.

3. The provisions of sections 376.2102 to 376.2114 shall not apply with regard to MO HealthNet.

376.2102. 1. No health carrier or utilization review entity shall require a health care provider to obtain prior authorization for a particular health care service if, in the most recent six-month evaluation period, as described in subsection 2 of this section, the health carrier or utilization review entity has approved not less than ninety

percent of the prior authorization requests submitted by that provider for that particular health care service.

2. Except as otherwise provided in subsection 3 of this section, a health carrier or utilization review entity shall evaluate whether a health care provider qualifies for a prior authorization provider exemption once every six months.

3. A health carrier or utilization review entity may continue an existing prior authorization provider exemption without evaluating whether the provider qualifies for the exemption for a particular evaluation period.

376.2104. 1. A prior authorization provider exemption shall remain in effect until:

(1) The thirtieth day after the date the health carrier or utilization review entity notifies the provider of the carrier's or entity's determination to rescind the exemption under section 376.2106, if the provider does not request an independent review of the determination under section 376.2108; or

(2) The fifth day after the date an independent review organization affirms the carrier's or entity's determination to rescind the exemption under section 376.2106, if the provider requests an independent review of the determination under section 376.2108.

2. If a health carrier or utilization review entity does not finalize a rescission determination in a manner described in subsection 1 of this section, the provider shall be considered to have met the criteria under section 376.2102 to continue to qualify for the exemption, and the exemption shall remain in effect.

376.2106. 1. A health carrier or utilization review entity shall rescind a prior authorization provider exception only:

(1) During January or July of each year;

(2) If the health carrier or utilization review entity makes a determination on the basis of a retrospective review of a random sample of not fewer than five and not more than twenty claims submitted by the provider during the most recent evaluation period described by subsection 2 of section 376.2102 that less than ninety percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health carrier or utilization review entity when conducting prior authorization review for the particular health care service during the relevant evaluation period;

(3) If the health carrier or utilization review entity notifies the provider not less than twenty-five days before the proposed rescission is to take effect; and

(4) If the health carrier provides with the notice under subdivision (3) of this subsection the following:

(a) The sample information used to make the determination under subdivision (2) of this subsection; and

(b) A plain language explanation of how the provider may request an independent review of the determination under section 376.2108.

2. A determination under subdivision (2) of subsection 1 of this section must be made by an individual licensed to practice medicine in this state. For a determination made under subdivision (2) of subsection 1 of this section with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

3. A health carrier or utilization review entity shall deny a prior authorization provider exemption only if:

(1) The provider does not have the exemption at the time of the relevant evaluation period; and

(2) The carrier or entity provides the provider with actual statistics and data for the relevant evaluation period and detailed information sufficient to demonstrate that the provider does not meet the criteria for a prior authorization provider exemption.

376.2108. 1. A provider shall have the right to a review of an adverse determination regarding a prior authorization provider exemption, which shall be conducted by an independent review organization. No health carrier or utilization review entity shall require a provider to engage in an internal appeals process before requesting a review by an independent review organization under this section.

2. A health carrier or utilization review entity shall pay:

(1) For any appeal or independent review of an adverse determination regarding a prior authorization provider exemption requested under this section; and

(2) A reasonable fee, to be determined by the Missouri state board of registration for the healing arts, for any copies of medical records or other documents requested from a provider during an independent review requested under this section.

3. An independent review organization shall complete a review of an adverse determination regarding a prior authorization provider exemption not later than the thirtieth day after the date a provider files the request for an independent review under this section.

4. A provider may request that the independent review organization consider another random sample of not less than five and not more than twenty claims submitted to the health carrier or utilization review entity by the provider during the relevant evaluation period for the relevant health care service as part of its review. If the provider makes a request under this subsection, the independent review organization shall base its determination on both the claims reviewed by the health carrier or utilization review entity under section 376.2106 and the claims included in the additional random sample requested under this subsection.

376.2110. 1. A health carrier or utilization review entity shall be bound by an independent review determination under section 376.2108 that does not affirm the determination made by the carrier or entity to deny or rescind a prior authorization provider exemption.

2. No health carrier or utilization review entity shall retroactively deny coverage for a health care service on the basis of a rescission of a prior authorization provider exemption, even if the carrier's or entity's determination to rescind the exemption is affirmed by an independent review organization.

3. If a health carrier's or utilization review entity's determination of a prior authorization provider exemption is overturned on review by an independent review organization, the carrier or entity:

(1) Shall not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(2) Shall only rescind the exemption thereafter if the carrier or entity complies with sections 376.2106 and 376.2108.

376.2112. After a final determination or review affirming the rescission or denial of a prior authorization provider exemption, a provider shall be eligible for consideration for an exemption for the same health care service after the evaluation period that follows the evaluation period which formed the basis of the rescission or denial.

376.2114. 1. No health carrier or utilization review entity shall deny or reduce payment to a provider for a health care service for which the provider has a prior authorization provider exemption in effect based on medical necessity or appropriateness of care unless the provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier or utilization review entity with the specific intent to deceive and obtain an unlawful payment from the carrier or entity; or

(2) Failed to substantially perform the health care service.

2. No health carrier or utilization review entity shall conduct a retrospective review of a health care service subject to a prior authorization provider exemption, except:

(1) To determine whether the provider still qualifies for a prior authorization provider exemption; or

(2) If the health carrier or utilization review entity has reasonable cause to suspect a basis for denial exists under subdivision (1) of this subsection.

3. For a retrospective review described by subdivision (2) of subsection 2 of this section, nothing in sections 376.2102 to 376.2114 shall be construed to modify or otherwise affect:

(1) The requirements under or application of section 376.1363, including any timeframes specified under that section; or

(2) Any other applicable law, except to prescribe the only circumstances under which:

(a) A retrospective utilization review may occur as specified in subdivision (2) of subsection 2 of this section; or

(b) Payment may be denied or reduced as specified in subdivision (1) of this subsection.

4. No later than five days after a provider qualifies for a prior authorization provider exemption, a health carrier or utilization review entity shall provide to the provider a notice that includes:

(1) A statement that the provider qualifies for a prior authorization provider exemption;

(2) A list of the health care services and health benefit plans to which the prior authorization provider exemption applies; and

(3) A statement of the duration of the exemption.

5. If a provider submits a prior authorization request for a health care service for which the provider qualifies for a prior authorization provider exemption, the health carrier or utilization review entity shall include in its response a notice to the provider which includes:

(1) The information described in subsection 4 of this section; and

(2) A notification of the health carrier's or utilization review entity's payment requirements.

6. Nothing in sections 376.2102 to 376.2114 shall be construed to:

(1) Authorize a provider to provide a health care service outside the scope of his or her applicable license; or

(2) Require a health carrier or utilization review entity to pay for a health care service described in subdivision (1) of this subsection.

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