SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
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SENATE BILL NO. 754

89TH GENERAL ASSEMBLY

Reported from the Committee on Critical Issues, April 23, 1998, with recommendation that the House Committee Substitute for Senate Substitute for Senate Committee Substitute for Senate Bill No. 754 Do Pass.
ANNE C. WALKER, Chief Clerk
L2566.11C

AN ACT

To repeal section 376.1361, RSMo Supp. 1997, relating to certain medical services, and to enact in lieu thereof five new sections relating to the same subject.

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

Section A. Section 376.1361, RSMo Supp. 1997, is repealed and five new sections enacted in lieu thereof, to be known as sections 376.1361, 1, 2, 3 and 4, to read as follows:

376.1361. 1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request by either the director of the department of health or the director of the department of insurance.

2. Any medical director who administers the utilization review program or oversees the review decisions shall be a qualified health care professional licensed in the state of Missouri. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. A health carrier shall issue utilization review decisions in a timely manner pursuant to the requirements of sections 376.1363, 376.1365 and 376.1367. A health carrier shall obtain all information required to make a utilization review decision, including pertinent clinical information. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

4. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

5. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health

EXPLANATION—Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

6. The health carrier shall coordinate the utilization review program with other medical management activities conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for accessing member satisfaction and risk management.

7. A health carrier shall provide enrollees and participating providers with timely access to its review staff by a toll-free number.

8. When conducting utilization review, the health carrier shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services.

9. Compensation to persons providing utilization review services for a health carrier shall not contain direct or indirect incentives for such persons to make medically inappropriate review decisions. Compensation to any such persons may not be directly or indirectly based on the quantity or type of adverse determinations rendered.

10. A health carrier shall permit enrollees or a provider on behalf of an enrollee to appeal for the coverage of medically necessary pharmaceutical prescriptions and durable medical equipment as part of the health carriers' utilization review process.

11. (1) This subsection shall apply to:

(a) Any health benefit plan that is issued, amended, delivered or renewed on or after January 1, 1998, and provides coverage for drugs; or

(b) Any person making a determination regarding payment or reimbursement for a prescription drug pursuant to such plan.

(2) A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate.

(3) This section shall not be construed to require coverage for a drug when the FDA has determined its use to be contraindicated for treatment of the current indication.

(4) A drug use that is covered pursuant to subsection 1 of this section shall not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use.

(5) Any drug or service furnished in a research trial, if the sponsor of the research trial furnishes such drug or service without charge to any participant in the research trial, shall not be subject to coverage pursuant to subsection 1 of this section.

(6) Nothing in this section shall require payment for nonformulary drugs, except that the state may exclude or otherwise restrict coverage of a covered outpatient drug from Medicaid programs as specified in the Social Security Act, Section 1927(d)(1)(B).

12. A carrier shall issue a confirmation number to an enrollee when the health carrier, acting through a participating provider or other authorized representative, **[**authorizes**]** **certifies** the provision of health care services. **A certification shall be deemed to be an authorization.**

13. If an authorized representative of a health carrier authorizes the provision of health care services, the health carrier shall not subsequently retract its authorization after the health care services

have been provided, or reduce payment for an item or service furnished in reliance on approval, unless

(1) Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or

(2) The health benefit plan terminates before the health care services are provided; or

(3) The covered person's coverage under the health benefit plan terminates before the health care services are provided.

Section 1. 1. A health services corporation shall allow enrollees to seek a second medical opinion or consultation from a willing second physician at no additional cost to the enrollee beyond what the enrollee would otherwise pay for an initial medical opinion or consultation from that second physician.

2. If an enrollee chooses to seek a second medical opinion, and if the health services corporation does not employ or contract with another physician with the expertise necessary to provide a second medical opinion, the health services corporation shall arrange for a referral to another physician with the necessary expertise to provide a second opinion or consultation and ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating physicians.

Section 2. 1. A health maintenance organization shall allow enrollees to seek a second medical opinion or consultation from the health maintenance organization's choice of other primary care physicians and specialty physicians at no additional cost to the enrollee beyond what the enrollee would otherwise pay for an initial medical opinion or consultation.

2. If an enrollee chooses to seek a second medical opinion, and if the health maintenance organization does not employ or contract with another physician with the expertise necessary to provide a second medical opinion, the health maintenance organization shall arrange for a referral to a physician with the necessary expertise to provide a second opinion or consultation and ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating physicians.

Section 3. The second opinions required in sections 1 and 2 of this act shall be covered only in the event that the original diagnosis requires major surgery or other treatment necessitating general anesthesia or other serious illness involving loss of bodily part or function or other debilitating disease.

Section 4. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. section 1001, et seq., this section shall apply to any health insurer, as defined in section 376.806, RSMo, nonprofit health service plan or health maintenance organization.

2. Within forty-five days after receipt of a claim for reimbursement from a person entitled to reimbursement, a health insurer, as defined in section 376.806, RSMo, nonprofit health service plan or health maintenance organization shall:

(1) Pay the claim in accordance with this section; or

(2) Send a notice of receipt and status of the claim that states that:

(a) The insurer, nonprofit health service plan or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal; or

(b) Additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary.

3. (1) If an insurer, nonprofit health service plan or health maintenance organization fails to comply with subsection 2 of this section, the insurer, nonprofit health service plan or

health maintenance organization shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one and one-half percent.

(2) The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

4. (1) Within ten days after the day on which all additional information is received by an insurer, nonprofit health service plan or health maintenance organization, it shall:

(a) Pay the claim in accordance with this section; or

(b) Send a written notice that:

a. States refusal to reimburse the claim or any part of the claim; and

b. Specifies each reason for denial.

(2) An insurer, nonprofit health service plan or health maintenance organization that fails to comply with subdivision (1) of this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one and one-half percent.