FIRST REGULAR SESSION

# HOUSE BILL NO. 899

## 96TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE COLONA.

1986L.01I D. ADAM CRUMBLISS, Chief Clerk

## AN ACT

To repeal sections 376.1350, 376.1359, 376.1361, 376.1363, 376.1367, 376.1372, 376.1375, 376.1378, 376.1382, 376.1385, 376.1387, 376.1389, and 376.1399, RSMo, and to enact in lieu thereof fourteen new sections relating to health care utilization review.

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

Section A. Sections 376.1350, 376.1359, 376.1361, 376.1363, 376.1367, 376.1372, 376.1375, 376.1378, 376.1382, 376.1385, 376.1387, 376.1389, and 376.1399, RSMo, are repealed and fourteen new sections enacted in lieu thereof, to be known as sections 376.1350, 376.1359, 376.1361, 376.1363, 376.1367, 376.1372, 376.1375, 376.1378, 376.1382, 376.1385, 376.1387, 376.1389, 376.1399, and 1, to read as follows:

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) **"Authorized representative":**

**(a) A person to whom an enrollee has given express written consent to represent the enrollee in an external review;**

**(b) A person authorized by law to provide substituted consent for an enrollee; or**

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

**(c) A family member of an enrollee or the enrollee's treating health care professional only when the enrollee is unable to provide consent;**

**(4) "Best evidence", evidence based on randomized clinical trials, or, if randomized clinical trials are not available, evidence based on cohort studies or case control studies, or if randomized clinical trials and cohort studies or case control studies are not available, evidence based on case series, or, if randomized clinical trials, cohort studies or case control studies, and case series are not available, evidence based on expert opinion;**

**(5) "Case control study", a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;**

**(6)** "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

**(7) "Case series", an evaluation of a series of patients with a particular outcome, without the use of a control group;**

**[**(4)**] (8)** "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

**[**(5)**] (9)** "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

**[**(6)**] (10)** "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

**(11) "Cohort study", a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or interventions;**

**[**(7)**] (12)** "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

**[**(8)**] (13)** "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

**[**(9)**] (14)** "Director", the director of the department of insurance, financial institutions and professional registration;

**[**(10)**] (15)** "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

**(16) "Disclose", to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;**

**[**(11)**] (17)** "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

**[**(12)**] (18)** "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition **[**that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child**] or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy**;

**[**(13)**] (19)** "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition**[**, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider**]**;

**[**(14)**] (20)** "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

**(21) "Evidence-based standard", the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;**

**(22) "Expert opinion", a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy;**

**[**(15)**] (23)** "FDA", the federal Food and Drug Administration;

**[**(16)**] (24)** "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

**(25) "Final adverse determination", an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures in accordance with the grievance procedures filed under section 376.1378;**

**[**(17)**] (26)** "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

**[**(18)**] (27)** "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services**[**; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy**] . Health benefit plan:**

**(a) Does not include the following coverage:**

**a. Coverage only for accident or disability income insurance, or any combination thereof;**

**b. Coverage issued as a supplement to liability insurance;**

**c. Liability insurance, including general liability insurance and automobile liability insurance;**

**d. Workers' compensation or similar insurance;**

**e. Automobile medical payment insurance;**

**f. Credit-only insurance;**

**g. Coverage for on-site medical clinics; or**

**h. Other similar insurance coverage, specified in federal regulations issued under Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits;**

**(b) Does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:**

**a. Limited scope dental or vision benefits;**

**b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;**

**c. Other similar limited scope benefits specified in federal regulations issued under Public Law 104-191;**

**(c) Does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:**

**a. Coverage only for a specified disease or illness; or**

**b. Hospital indemnity or other fixed indemnity insurance;**

**(d) Does not include the following if offered as a separate policy, certificate, or contract of insurance:**

**a. Medicare supplemental health insurance as defined in Section 1882(g)(1) of the Social Security Act;**

**b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, Civil Health and Medical Program of the Uniformed Services (CHAMPUS); or**

**c. Similar supplemental coverage provided to coverage under a group health plan**;

**[**(19)**] (28)** "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

**[**(20)**] (29)** "Health care provider" or "provider", a health care professional or a facility;

**[**(21)**] (30)** "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

**[**(22)**] (31)** "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

**[**(23)**] (32)** "Health indemnity plan", a health benefit plan that is not a managed care plan;

**(33) "Health information", information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:**

**(a) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;**

**(b) The provision of health care services to an individual; or**

**(c) Payment for the provision of health care services to an individual;**

**(34) "Independent review organization", an entity that conducts independent external reviews of adverse determinations and final adverse determinations;**

**(35) "Medical or scientific evidence", evidence found in the following sources:**

**(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;**

**(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);**

**(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;**

**(d) The following standard reference compendia:**

**a. The American Hospital Formulary Service - Drug Information;**

**b. Drug Facts and Comparisons;**

**c. The American Dental Association Accepted Dental Therapeutics; and**

**d. The United States Pharmacopoeia - Drug Information;**

**(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:**

**a. The federal Agency for Healthcare Research and Quality;**

**b. The National Institutes of Health;**

**c. The National Cancer Institute;**

**d. The National Academy of Sciences;**

**e. The Centers for Medicare & Medicaid Services;**

**f. The federal Food and Drug Administration; and**

**g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or**

**(f) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (a) to (e) of this subdivision;**

**[**(24)**] (36)** "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

**[**(25)**] (37)** "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

**[**(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27)**] (38)** "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

**[**(28)**] (39)** "Prospective review", utilization review conducted prior to an admission or a course of treatment;

**(40) "Protected health information", health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual;**

**(41) "Randomized clinical trial", a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;**

**[**(29)**] (42)** "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

**[**(30)**] (43)** "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

**[**(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33)**] (44)** "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

**[**(34)**] (45)** "Utilization review organization", **[**a utilization review agent as defined in section 374.500**] an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit**.

376.1359. 1. A health carrier that conducts utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program document shall describe information as required by the director.

2. A health carrier shall file an annual report of its utilization review program activities with the director.

**3. In addition to the summary report required to be filed under subsection 2 of this section, a health carrier shall maintain records for a minimum of six years for all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with the provisions of sections 376.1350 to 376.1399.**

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 and senior services or the director of the department of insurance, financial institutions and professional registration.

2. Any **[**medical director**] qualified health care professional** 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. **(1)** 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. **A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.**

**(2) If a health carrier fails to strictly adhere to the requirements of sections 376.1363, 376.1365, and 376.1367 with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of sections 376.1363, 376.1365, and 376.1367, and may file a request for external review under section 376.1387, regardless of whether the health carrier asserts that it substantially complied with the requirements of sections 376.1363, 376.1365, and 376.1367, as applicable, or that any error that it committed was de minimus.**

**(3) In addition to external review as described in subdivision (2) of this subsection and in section 376.1387, an enrollee is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeal process that would yield a decision on the merits of the claim.**

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 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. **The health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.**

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**] A health carrier shall not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits**.

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 the provision of health care services.

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.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For initial determinations, a health carrier shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the enrollee and the provider within two working days of making the initial certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one working day of

making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of the telephone notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include **[**the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and**] information sufficient to identify the benefit request or claim involved, including the date of service if applicable, the health care provider, the claim amount if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; the specific reason or reasons for the determination, including the denial code and its corresponding meaning and a description of the health carrier's standard, if any, that was used in denying the benefit request or claim; and** the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

**7. A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required, in accordance with federal regulations.**

376.1367. When conducting utilization review or making a benefit determination for emergency services:

(1) A health carrier **that provides benefits for services in an emergency department of a hospital** shall cover emergency services **[**necessary to screen and stabilize an enrollee and shall not require prior authorization of such services**] to screen and stabilize a covered person in the following manner:**

**(a) Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;**

**(b) Emergency services shall be covered whether the health care provider furnishing the services is a participating provider with respect to such services;**

**(c) If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers**;

(2) Coverage of emergency services shall be subject to applicable co-payments, coinsurance and deductibles;

(3) When an enrollee receives an emergency service that requires immediate post evaluation or post stabilization services, a health carrier shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within thirty minutes, such services shall be deemed approved.

376.1372. 1. In the certificate of coverage and the member handbook provided to enrollees, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of enrollees with respect to those procedures.

2. A health carrier shall include a summary of its utilization review procedures in material intended for prospective enrollees.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

**4. A health carrier shall provide the description of the utilization review procedures required under this section in a culturally and linguistically appropriate manner if required, in accordance with federal regulations.**

376.1375. 1. A health carrier shall maintain a written register of all grievances **[**in a manner consistent with the requirements for maintaining complaint records pursuant to section 354.445**] received, including the notices and claims associated with the grievances, during the calendar year**. The grievance register shall contain the total number, type, nature and result of all grievances and such other information as may be prescribed by the director. A health carrier shall furnish the director with any records regarding a grievance upon request.

2. **A health carrier shall maintain the records required under subsection 1 of this section related to decisions issued by the health carrier for at least six years. The health carrier shall make the records available for examination by enrollees, the director, and appropriate federal oversight agencies upon request.**

**3.** All grievances shall be date stamped when received by the health carrier. The date shall be legible and easily identified.

**[**3.**] 4.** Upon receipt of any inquiry from the department of insurance, financial institutions and professional registration regarding a grievance, a health carrier shall mail to the department an adequate response to the inquiry within twenty days from the date the department mails the inquiry. An envelope's postmark shall determine the date of mailing. When the requested response is not produced by the health carrier within twenty days, this nonproduction shall be deemed a violation of law, unless the person can demonstrate that there is reasonable justification for that delay. As used in this section:

(1) "Inquiry", each and every question or request for information submitted in writing to a health carrier by the department concerning a grievance;

(2) "Adequate response", a written response answering each inquiry with reasonable specificity. A health carrier's acknowledgment of the department's inquiry is not an adequate response.

376.1378. 1. A copy of the grievance procedures, including all forms used to process a grievance, shall be filed with the director. Any subsequent material modifications to the documents also shall be filed. In addition, a health carrier shall file annually with the director, as part of its annual report required by section 376.1375, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of sections 376.1350 to 376.1390. The director has authority to disapprove a filing that fails to comply with sections 376.1350 to 376.1390 or applicable rules and regulations.

2. A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to enrollees.

3. The grievance procedure documents shall include a statement of an enrollee's right to contact the director's office for assistance at any time. The statement shall include the toll-free telephone number and address of the department of insurance, financial institutions and professional registration.

4. **If a health carrier fails to strictly adhere to the requirements of sections 376.1382 and 376.1389 with respect to receiving and resolving grievances involving an adverse determination, the enrollee shall be deemed to have exhausted the provisions of sections**

**376.1382 to 376.1389, and may file a request for external review under the provisions of section 376.1387, regardless of whether the health carrier asserts that it substantially complied with the requirements of sections 376.1382 to 376.1389, as applicable, or that any error that it committed was de minimus.**

**5.** No such grievance procedure shall act as a bar to any suit in a court of competent jurisdiction instituted by any such enrollee, or as a bar to any defense thereto by the health carrier.

**[**5.**] 6.** In the event there is a conflict between the outcomes of the grievance procedure and any such suit, the outcome of the suit in a court of competent jurisdiction shall prevail.

376.1382. 1. A health carrier **[**that offers managed care plans shall establish a first-level and second-level grievance review process for its managed care plans**] shall establish a grievance review process**. A grievance may be submitted by an enrollee, an enrollee's representative or a provider acting on behalf of an enrollee.

2. Upon receipt of a request for **[**first-level**]** grievance review, a health carrier shall:

(1) Acknowledge receipt in writing of the grievance within ten working days;

(2) Conduct a complete investigation of the grievance within twenty working days after receipt of a grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty working days after receipt of a grievance, the enrollee shall be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;

(3) Within five working days after the investigation is completed, have someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the health carrier's decision regarding the grievance **[**and of the right to file an appeal for a second-level review**]**. The notice shall explain the resolution of the grievance and the right to appeal in terms which are clear and specific;

(4) Within fifteen working days after the investigation is completed, notify the person who submitted the grievance of the carrier's resolution of said grievance.

**3. (1) Prior to issuing a decision under the timelines outlined in subsection 2 of this section, the health carrier shall provide free of charge to the enrollee or the enrollee's authorized representative any new or additional evidence relied upon generated by the health carrier, or at the discretion of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative in a reasonable opportunity to respond prior to such date.**

**(2) Before the health carrier issues or provides notice of a final adverse determination under the timelines outlined in subsection 2 of this section that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the enrollee, or the enrollee's authorized representative free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the enrollee or the enrollee's authorized representative a reasonable opportunity to respond prior to such date.**

376.1385. 1. **A health carrier that offers managed care plans shall establish a second-level review process for its managed care plans. A second-level grievance may be submitted by an enrollee, an enrollee's representative, or a provider acting on behalf of an enrollee.** Upon receipt of a request for second-level review, a health carrier shall submit the grievance to a grievance advisory panel consisting of:

(1) Other enrollees;

(2) Representatives of the health carrier that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and

(3) Where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

2. Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office.

376.1387. 1. The director shall resolve any grievance regarding **[**an adverse determination as to**]** **a final adverse determination based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a** covered services appealed by an enrollee or health carrier or plan sponsor through **[**any means not specifically prohibited by law but if the grievance is unresolved by the director then it shall be resolved**]** by referral of such grievance to an independent review organization.

**2.** The director shall **[**establish the qualifications for such review organizations(s)**]** **approve independent review organizations eligible to be assigned to conduct external reviews under the provisions of this section** and shall seek the services of such **[**organization(s)**]** **organization or organizations** by competitive bid pursuant to chapter 34. The

director shall enter into contracts with such **[**organization(s)**] organization or organizations** as deemed necessary to conduct the adverse determination appeals process set forth in this section. Any request for an adverse determination appeal shall be assigned on a rotational basis. The organization's decision as to the resolution of the grievance shall be based upon a review of the written record before it. The grievance and resolution of such grievance shall not be considered a contested case within the meaning of section 536.010, but the resolution of such grievance by the panel shall be considered a final agency decision within the director's discretion, binding upon the enrollee and health carrier, and subject to judicial review if:

(1) Action for such review is filed within thirty days of the final agency decision; and

(2) Judicial review is limited to the record before the director; and

(3) The enrollee and health carrier are deemed real parties in interest; and

(4) The scope of judicial review extends only to a determination of whether the action of the director is unconstitutional, unlawful, unreasonable, arbitrary, or capricious or involves an abuse of discretion or is in excess of the statutory authority or jurisdiction of the director.

**[**2.**] 3.** Nothing in this section is intended to restrict the director's authority to investigate and resolve any complaint against a health carrier that does not constitute a grievance within the meaning of section 376.1350.

**[**3.**] 4.** Any grievance involving coverage provided **[**pursuant to a Medicaid**] under a MO HealthNet** program, however, shall be resolved in accordance with the rules and procedures established for the **[**Medicaid**] MO HealthNet** program.

376.1389. 1. A health carrier shall establish written procedures for the expedited review of a grievance involving a situation where the time frame of the standard grievance procedures set forth in sections 376.1382 and 376.1385 would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, for purposes of the grievance register requirements in section 376.1375, the request shall not be considered a grievance unless the request is submitted in writing. Expedited review procedures shall be available to an enrollee, the representative of an enrollee and to the provider acting on behalf of an enrollee.

2. A health carrier shall notify an enrollee orally within **[**seventy-two**] twenty-four** hours after receiving a request for an expedited review of the carrier's determination, and shall provide written confirmation of its decision covering an expedited review within three working days of providing notification of the determination. **[**The provisions of sections 376.1350 to 376.1390 are not applicable to health indemnity plans without a managed care component as defined in 376.1350.**]**

376.1399. **The director may promulgate rules to implement the provisions of sections 376.1350 to 376.1399.** Any rule or portion of a rule promulgated pursuant to **[**this act**]** **sections 376.1350 to 376.1399** shall become effective only as provided pursuant to chapter 536, including, but not limited to, section 536.028, if applicable, after August 28, 1997. All rulemaking authority delegated prior to August 28, 1997, is of no force and effect and repealed. The provisions of **[**this section**]** **sections 376.1350 to 376.1399** are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028, if applicable, to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void.

**Section 1. Notwithstanding the provision of section 391.227 to the contrary, a health care provider shall not charge or attempt to collect a fee for the costs of the reproduction or copying of health care records or health information provided to the division of consumer affairs within the department of insurance, financial institutions and professional registration when:**

**(1) The division has been duly authorized to obtain health care records or health information by the enrollee or the enrollee's authorized representative; and**

**(2) Such request is made in connection with:**

**(a) The investigation of a consumer complaint filed with the division by the health care provider or the enrollee or enrollee's authorized representative under section 374.085;**

**(b) The assistance provided by the division to the enrollee or the enrollee's authorized representative in filing a first- or second-level grievance and appeal with such enrollee's health benefit plan under sections 376.1350 to 376.1399; or**

**(c) The division's review of the eligibility of or preparation of the submission of a final adverse determination to an independent review organization under section 376.1387.**

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