SECOND REGULAR SESSION

HOUSE BILL NO. 2089

91ST GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE TROUPE.

Read 1st time February 28, 2002, and 1000 copies ordered printed.

TED WEDEL, Chief Clerk

4538L.01I

AN ACT

To repeal sections 354.442, 374.500, 376.810, 376.1350, 376.1361, 379.944, and 475.123, RSMo, and to enact in lieu thereof seven new sections relating to the determination of medical necessity.

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

Section A. Sections 354.442, 374.500, 376.810, 376.1350, 376.1361, 379.944, and 475.123, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 354.442, 374.500, 376.810, 376.1350, 376.1361, 379.944, and 475.123, to read as follows:

354.442. 1. Each enrollee, and upon request each prospective enrollee prior to enrollment, shall be supplied with written disclosure information. In the event of any inconsistency between any separate written disclosure statement and the enrollee contract or evidence of coverage, the terms of the enrollee contract or evidence of coverage shall be controlling. The information to be disclosed in writing shall include at a minimum the following:

(1) A description of coverage provisions, health care benefits, benefit maximums, including benefit limitations;

(2) A description of any exclusions of coverage, including **[**the definition of**] a statement that** medical necessity**,** used in determining whether benefits will be covered**, is determined solely by the treating licensed health care provider**;

(3) A description of all prior authorization or other requirements for treatments and services;

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

(4) A description of utilization review policies and procedures used by the health maintenance organization, including:

(a) The circumstances under which utilization review shall be undertaken;

(b) The toll-free telephone number of the utilization review agent;

(c) The time frames under which utilization review decisions shall be made for prospective, retrospective and concurrent decisions;

(d) The right to reconsideration;

(e) The right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(f) The right to designate a representative;

(g) A notice that all denials of claims shall be made by qualified clinical personnel and that all notices of denial shall include information about the basis of the decision; and

(h) Further appeal rights, if any;

(5) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization;

(6) An explanation of an enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization's network or by any provider without required authorization, or when a procedure, treatment or service is not a covered health care benefit;

(7) A description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including:

(a) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization;

(b) The right to file a grievance when the dispute is about referrals or covered benefits;

(c) The toll-free telephone number which enrollees may use to file a grievance;

(d) The department of insurance's toll-free consumer complaint hot line number;

(e) The time frames and circumstances for expedited and standard grievances;

(f) The right to appeal a grievance determination and the procedures for filing such an appeal;

(g) The time frames and circumstances for expedited and standard appeals;

(h) The right to designate a representative;

(i) A notice that all disputes involving clinical decisions shall be made by qualified clinical personnel; and

(j) All notices of determination shall include information about the basis of the decision and further appeal rights, if any;

(8) A description of a procedure for providing care and coverage twenty-four hours a day, seven days a week, for emergency services. Such description shall include the definition of emergency services and emergency medical condition, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area;

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(11) Notice that an enrollee may obtain a referral for covered services to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee may obtain such referral;

(12) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(13) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(14) A listing by specialty, which may be in a separate document that is updated annually, of the names, addresses and telephone numbers of all participating providers, including facilities, and in addition in the case of physicians, board certification; and

(15) The director of the department of insurance shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of insurance may approve a supplement to the standard credentialing form. All forms and supplements shall meet all requirements as defined by the National Committee of Quality Assurance.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee, provide the following:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(2) A copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) A copy of the most recent individual, direct pay enrollee contracts;

(4) Information relating to consumer complaints compiled annually by the department of insurance;

(5) The procedures for protecting the confidentiality of medical records and other enrollee information;

(6) An opportunity to inspect drug formularies used by such health maintenance organization and any financial interest in a pharmacy provider utilized by such organization. The health maintenance organization shall also disclose the process by which an enrollee or his representative may seek to have an excluded drug covered as a benefit;

(7) A written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(8) A description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) Individual health **[**practitioner**] practitioner's** affiliations with participating hospitals, if any;

(10) Upon written request, written clinical review criteria relating to conditions or diseases and, where appropriate, other clinical information which the organization may consider in its utilization review. The health maintenance organization may include with the information a description of how such information will be used in the utilization review process;

(11) The written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(12) A description of the procedures followed by the health maintenance organization in making decisions about which drugs to include in the health maintenance organization's drug formulary.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

374.500. As used in sections 374.500 to 374.515, the following terms mean:

(1) "Certificate", a certificate of registration granted by the department of insurance to a utilization review agent;

(2) "Director", the director of the department of insurance;

(3) "Enrollee", an individual who has contracted for or who participates in coverage under a health insurance policy, an employee welfare benefit plan, a health services corporation

plan or any other benefit program providing payment, reimbursement or indemnification for health care costs for himself or eligible dependents or both himself and eligible dependents. The term "enrollee" shall not include an individual who has health care coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(4) "Provider of record", the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment and services rendered to an enrollee;

(5) "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 **or review of medical necessity which shall be determined solely by the treating licensed health care provider**;

(6) "Utilization review agent", any person or entity performing utilization review, except:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government; or

(c) Any individual person employed or used by a utilization review agent for the purpose of performing utilization review services, including, but not limited to, individual nurses and physicians, unless such individuals are providing utilization review services to the applicable benefit plan, pursuant to a direct contractual relationship with the benefit plan;

(d) An employee health benefit plan that is self-insured and qualified pursuant to the federal Employee Retirement Income Security Act of 1974, as amended;

(e) A property-casualty insurer or an employee or agent working on behalf of a property-casualty insurer;

(f) A health carrier, as defined in section 376.1350, RSMo, that is performing a review of its own health plan;

(7) "Utilization review plan", a summary of the utilization review procedures of a utilization review agent.

376.810. As used in sections 376.810 to 376.814, the following terms mean:

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Community mental health center", a legal entity certified by the department of

mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals;

(3) "Day program services", a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization;

(4) "Episode", a distinct course of chemical dependency treatment separated by at least thirty days without treatment;

(5) "Health insurance policy", all group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not-for-profit health services corporation, all self-insured group health benefit plans of any type or description to the extent that regulation of such plans is not preempted by federal law, and all such health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families as nongroup policies, which provide for hospital treatment. For the purposes of subsection 2 of section 376.811, "health insurance policy" shall also include any group or individual contract issued by a health maintenance organization. The provisions of sections 376.810 to 376.814 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(6) "Licensed professional", a licensed physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor. Only prescription rights under this act shall apply to medical physician's and doctors of osteopathy;

(7) "Managed care", the determination of availability of coverage under a health insurance policy through the use of clinical standards to determine the **[**medical necessity**]** **appropriateness** of an admission or treatment, and the level and type of treatment, and **the** appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, sometimes involving case management**; except that, medical necessity shall be determined solely by the treating licensed health care provider**;

(8) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with chemical dependency;

(9) "Nonresidential treatment program", program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting;

(10) "Recognized mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation;

(11) "Residential treatment program", program certified by the department of mental

health involving residential care and structured, intensive treatment;

(12) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

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**. The health carrier shall not have the authority to review medical necessity, which shall be determined solely by the treating licensed health care provider**;

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

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

(4) "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**. The health carrier shall not have the authority to determine medical necessity, which shall be determined solely by the treating licensed health care provider**;

(5) "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) "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;

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

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

(9) "Director", the director of the department of insurance;

(10) "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;

(11) "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) "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;

(13) "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) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "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;

(17) "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) "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;

(19) "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) "Health care provider" or "provider", a health care professional or a facility;

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

(22) "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;

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

(24) "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) "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) "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) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

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

(30) "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) "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 **or review of medical necessity which shall be determined solely by the treating licensed health care provider**;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500, RSMo.

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.

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 **of the treating licensed health care provider** 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 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**] which shall be determined solely by the treating licensed health care provider**.

(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.

379.944. 1. The director shall appoint a seven-member "Health Benefit Plan Committee". The committee shall be composed of one representative from each of the following categories: an insurance company which is a small employer carrier, a health services corporation which is a small employer carrier, a health maintenance organization which is a small employer carrier, a health care provider, and a small employer. The director shall select two representatives of employees of small employers, including at least one representative of a labor organization.

2. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to sections 379.942 and 379.943.

3. The committee shall recommend benefit levels, cost sharing levels, exclusions and

limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the committee shall include cost containment features such as:

(a) Utilization review of health care services, including review of **[**medical necessity**]** **appropriateness** of hospital and physician services**. Medical necessity shall not be included as a cost containment feature and shall be determined solely by the treating licensed health care provider**;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

(2) The committee shall submit the health benefit plans described in this subsection to the director for approval within one hundred eighty days after the appointment of the committee.

475.123. 1. No medical or surgical procedure shall be performed on any ward unless consent is obtained from the guardian of **[**his**]** **the ward's** person except as provided in subsections 2 and 3 hereof.

2. If the life of the ward is threatened and there is not time to obtain consent, a medical or surgical procedure may be performed without consent after the medical necessity**, to be determined solely by the treating licensed health care provider,** for the procedure has been documented in the medical record of the ward.

3. If the life of a person is threatened and his **or her** consent to a necessary medical or surgical procedure cannot be obtained, a court, on petition filed pursuant to section 475.060, after hearing, may authorize consent on behalf of such person.

4. Any hearing conducted pursuant to subsection 3 of this section, involving a life threatening medical emergency, may be conducted within or without the county at the medical facility where the person has been admitted with such notice and in such form as is practicable considering the time limitations imposed due to the condition of person. The fact of attempted oral notice to persons interested in the welfare of the person shall be made a part of the record of the hearing.