AN ACT

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

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

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

376.2100. 1. Except as otherwise provided in subsection 1 of section 376.2108, as used in sections 376.2100 to 376.2108, terms shall have the same meanings as are ascribed to them under section 376.1350.

2. As used in sections 376.2100 to 376.2108, the term "evaluation period" shall mean the first six months of the calendar year or the last six months of the calendar year.

376.2102. 1. A health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for a health care service unless an individual licensed to practice medicine in this state makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of the prior authorization requests submitted by that provider for that health care service.

2. A health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for any health care services unless an individual licensed to practice medicine in this state makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would
have approved less than ninety percent of all prior authorization requests submitted by
that provider for health care services.

3. In making a determination under this section, the individual licensed to
practice medicine in this state shall not count any prior authorization requests denied by
a health carrier or utilization review entity and being appealed by the health care
provider, but shall count as approved any prior authorization request that was denied
by a health carrier or utilization review entity but that was subsequently authorized.

4. If the provider is a physician licensed under chapter 334, any determination
under this section shall be made by a physician licensed under chapter 334 who has the
same or similar specialty as the provider.

376.2104. 1. The health carrier or utilization review entity shall notify the health
care provider no later than twenty-five days after the conclusion of the relevant
evaluation period of any determination made under section 376.2102. The notification
shall include the statistics, data, and any supporting documentation for making the
determination for the relevant evaluation period.

2. The health carrier or utilization review entity shall maintain an online portal
to allow health care providers to access all prior authorization decisions, including
determinations made under section 376.2102. For health care providers subject to prior
authorizations, the portal shall include the status of each prior authorization request, all
notifications to the health care provider, the dates the health care provider received such
notifications, and any other information relevant to the determination.

3. If the notification is of a determination made under subsection 1 of section
376.2102, a health carrier or utilization review entity may require prior authorization
for the health care service, beginning fifteen business days after the provider receives
notification of the determination until the end of the evaluation period.

4. Except as otherwise provided in subsection 1 of section 376.2102, if the
notification is of a determination made under subsection 2 of section 376.2102, a health
carrier or utilization review entity may require prior authorization for all health care
services, beginning fifteen business days after the provider receives notification until the
end of the evaluation period.

5. Failure to notify the health care provider of a determination made under
subsection 1 of section 376.2102 shall constitute prior authorization for that health care
service.

6. Failure to notify the health care provider of a determination made under
subsection 2 of section 376.2102 shall constitute prior authorization for all health care
services.
376.2106. No health carrier or utilization review entity shall deny or reduce payment to a provider for a health care service for which the provider has a prior authorization unless the provider:

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

2. Failed to substantially perform the health care service.

376.2108. 1. The provisions of sections 376.2100 to 376.2108 shall not apply to MO HealthNet, except that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108.

2. The provisions of sections 376.2100 to 376.2108 shall not apply to health care providers who have not participated in a health benefit plan offered by the carrier for at least one full evaluation period.

3. Nothing in sections 376.2100 to 376.2108 shall be construed to:

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

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