SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 928

99TH GENERAL ASSEMBLY

Reported from the Committee on Health and Pensions, March 8, 2018, with recommendation that the Senate Committee Substitute do pass.

ADRIANE D. CROUSE, Secretary.

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AN ACT

To repeal sections 376.384, 376.427, and 376.1367, RSMo, and to enact in lieu thereof four new sections relating to health insurer reimbursement practices.

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

Section A. Sections 376.384, 376.427, and 376.1367, RSMo, are repealed
2 and four new sections enacted in lieu thereof, to be known as sections 376.384,
3 376.427, 376.690, and 376.1367, to read as follows:

376.384. 1. All health carriers shall:
2 (1) Permit nonparticipating health care providers to file a claim for
3 reimbursement for a health care service provided in this state as defined in
4 section 376.1350 for a period of up to one year from the date of service;
5 (2) Permit participating health care providers to file a claim for
6 reimbursement for a health care service provided in this state for a period of up
7 to six months from the date of service, unless the contract between the health
8 carrier and health care provider specifies a different standard;
9 (3) Not request a refund or offset against a claim more than twelve
10 months after a health carrier has paid a claim except in cases of fraud or
11 misrepresentation by the health care provider;
12 (4) Issue within one working day a confirmation of receipt of an
13 electronically filed claim.
14 2. **No health carrier shall reduce payments for evaluation and
15 management services that are otherwise eligible for reimbursement
16 when reported by the same provider on the same day as a procedure,
17 including but not limited to minor surgery.**

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

18 **3.** On or after January 1, 2003, all claims for reimbursement for a health
19 care service provided in this shall be submitted in an electronic format consistent
20 with federal administrative simplification standards adopted pursuant to the
21 Health Insurance Portability and Accountability Act of 1996. Any claim
22 submitted by a health care provider after January 1, 2003, in a nonelectronic
23 format shall not be subject to the provisions of section 376.383. Any health
24 carrier shall provide readily accessible electronic filing after this date to health
25 care providers.

26 **[**3.**]** **4.** On or after January 1, 2002, the director of the department of
27 insurance, financial institutions and professional registration shall monitor
28 health carrier compliance with the provisions of this section and section
29 376.383. Examinations, which may be based upon statistical samplings, to
30 determine compliance may be conducted by the department or the director may
31 contract with a qualified private entity. Compliance shall be defined as properly
32 processing and paying ninety-five percent of all claims received in a given
33 calendar year in accordance with the provisions of this section and section
34 376.383. The director may assess an administrative penalty in addition to the
35 penalties outlined in section 376.383 of up to twenty-five dollars per claim for the
36 percentage of claims found to be in noncompliance, but not to exceed an annual
37 aggregate penalty of two hundred fifty thousand dollars, for any health carrier
38 deemed to be not in compliance with this section and section 376.383. Any
39 penalty assessed pursuant to this subsection shall be assessed in addition to
40 penalties provided for pursuant to sections 375.942 and 375.1012.

41 **[**4.**]** **5.** If the director finds that health carriers are failing to make
42 interest payments to health care professionals authorized by section 376.383, the
43 director is authorized to order such health carriers to remit such interest
44 payments. The director is also authorized to assess a monetary penalty, payable
45 to the state of Missouri, in a sum not to exceed twenty-five percent of the unpaid
46 interest payment against health carriers.

47 **[**5.**]** **6.** A health carrier may request a waiver of the requirements of this
48 section and section 376.383 if the basis for the request is an act of God or other
49 good cause as determined by the director.

50 **[**6.**]** **7.** The director shall develop a method by which health care
51 providers may submit complaints to the department identifying violations of this
52 section and section 376.383 by a health carrier. The director shall consider such
53 complaints when determining whether to examine a health carrier's

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54 compliance. Prior to filing a complaint with the department, health care
55 providers who believe that a health carrier has not paid a claim in accordance
56 with this section and section 376.383 shall first contact the health carrier to
57 determine the status of the claim to ensure that sufficient documentation
58 supporting the claim has been provided and to determine whether the claim is
59 considered to be complete. Complaints to the department regarding the payment
60 of claims by a health carrier should contain information such as:

61 (1) The health care provider's name, address, and daytime phone number;

62 (2) The health carrier's name;

63 (3) The dates of service and the dates the claims were filed with the
64 health carrier;

65 (4) Relevant correspondence between the health care provider and the
66 health carrier, including requests from the health carrier for additional
67 information; and

68 (5) Additional information which the health care provider believes would
69 be of assistance in the department's review.

70 **[**7.**]** **8.** On or after January 1, 2003, all claims submitted electronically
71 for reimbursement for a health care service provided in this state shall be
72 submitted in a uniform format utilizing standard medical code sets. The uniform
73 format and the standard medical code sets shall be promulgated by the
74 department of insurance, financial institutions and professional registration
75 through rules consistent with but no more stringent than the federal
76 administrative simplification standards adopted pursuant to the Health
77 Insurance Portability and Accountability Act of 1996.

78 **[**8.**]** **9.** The department shall have authority to promulgate rules for the
79 implementation of section 376.383 and this section. Any rule or portion of a rule,
80 as that term is defined in section 536.010, that is created under the authority
81 delegated in this section shall become effective only if it complies with and is
82 subject to all of the provisions of chapter 536 and if applicable, sections
83 536.028. This section and chapter 536 are nonseverable and if any of the powers
84 vested with the general assembly pursuant to chapter 536 to review, to delay the
85 effective date or to disapprove and annul a rule subsequently held
86 unconstitutional, then the grant of rulemaking authority and any rule proposed
87 or adopted after August 28, 2001, shall be invalid and void.

376.427. 1. As used in this section, the following terms mean:

2 (1) "Health care services", medical, surgical, dental, podiatric,

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3 pharmaceutical, chiropractic, licensed ambulance service, and optometric services;
4 (2) "Insured", any person entitled to benefits under a contract of accident
5 and sickness insurance, or medical-payment insurance issued as a supplement to
6 liability insurance but not including any other coverages contained in a liability
7 or a workers' compensation policy, issued by an insurer;
8 (3) "Insurer", any person, reciprocal exchange, interinsurer, fraternal
9 benefit society, health services corporation, self-insured group arrangement to the
10 extent not prohibited by federal law, or any other legal entity engaged in the
11 business of insurance;
12 (4) "Provider", a physician, hospital, dentist, podiatrist, chiropractor,
13 pharmacy, licensed ambulance service, or optometrist, licensed by this state.
14 2. Upon receipt of an assignment of benefits made by the insured to a
15 provider, the insurer shall issue the instrument of payment for a claim for
16 payment for health care services in the name of the provider. All claims shall be
17 paid within thirty days of the receipt by the insurer of all documents reasonably
18 needed to determine the claim.
19 3. Nothing in this section shall preclude an insurer from voluntarily
20 issuing an instrument of payment in the single name of the provider.
21 4. **Except as provided in subsection 5 of this section,** this section
22 shall not require any insurer, health services corporation, health maintenance
23 corporation or preferred provider organization which directly contracts with
24 certain members of a class of providers for the delivery of health care services to
25 issue payment as provided pursuant to this section to those members of the class
26 which do not have a contract with the insurer.
27 **5. Payment for all services shall be made directly to the**
28 **providers when the carrier has authorized the patient to seek such**
29 **services from a provider outside the carrier's network.**
376.690. 1. For purposes of this section, the following terms shall
2 **mean:**
3 **(1) "Unanticipated out-of-network care", services received by a**
4 **patient in an in-network facility from an out-of-network health care**
5 **professional when the patient did not have the opportunity and ability**
6 **to select such services from an in-network health care professional, or**
7 **emergency services provided to a patient by an out-of-network health**
8 **care professional. Unanticipated out-of-network care shall not include**
9 **non-emergency services received by a patient when the patient**

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10 **voluntarily selects in writing an out-of-network health care**
11 **professional prior to receiving care;**
12 **(2) "Facility", the same meaning given to such term in section**
13 **376.1350;**
14 **(3) "Health care professional", the same meaning given to such**
15 **term in section 376.1350;**
16 **(4) "Health carrier", the same meaning given to such term in**
17 **section 376.1350;**
18 **2. Health care professionals shall send any bill for charges**
19 **incurred for unanticipated out-of-network care to the patient's health**
20 **carrier. The health carrier shall pay the health care professional**
21 **directly.**
22 **(1) The health carrier shall pay the health care professional the**
23 **greater of the usual and customary rate for the particular health care**
24 **service performed by health care professionals in the same or similar**
25 **specialty and in the same geographic area, or the carrier's average in-**
26 **network reimbursement for the service provided.**
27 **(2) A health care professional shall not send a bill to the patient**
28 **for any difference between the payment received and the payment that**
29 **would have been received if the payment was based on the rate charged**
30 **by the health care professional.**
31 **3. When unanticipated out-of-network care is provided, the**
32 **health care professional may bill a patient for no more than the cost-**
33 **sharing requirements that would be applicable if the services had been**
34 **provided by an in-network professional.**
35 **(1) Cost-sharing requirements shall be based on the payment**
36 **received by the health care professional as determined under**
37 **subdivision (1) of subsection 2 of this section.**
38 **(2) The patient's health carrier shall inform the health care**
39 **professional of its enrollee's cost-sharing requirements within ten**
40 **business days of receiving a bill from the health care professional for**
41 **services provided.**
42 **(3) For purposes of an enrollee's deductible and out-of-pocket**
43 **maximum, cost-sharing payments to the health care professional shall**
44 **be treated by the health carrier as though they were paid to an in-**
45 **network professional.**
46 **4. The director of the department of insurance, financial**

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47 **institutions, and professional registration shall ensure access to a**
48 **mediation process when a health care professional objects to the**
49 **application of the established payments described in this section. The**
50 **department shall determine usual and customary rates based on**
51 **benchmarks from independent nonprofit organizations that are not**
52 **affiliated with insurance carriers or provider organizations.**
53 **5. A health care professional may initiate mediation if the health**
54 **care professional believes payment received for unanticipated out-of-**
55 **network care does not properly recognize:**
56 **(1) The health care professional's training, education, and**
57 **experience;**
58 **(2) The nature of the service provided;**
59 **(3) The health care professional's usual charge for comparable**
60 **services provided;**
61 **(4) The circumstances and complexity of the particular case,**
62 **including time and place of services; and**
63 **(5) Other aspects of the health care professional's practice that**
64 **may be relevant to the payment.**
65 **6. Health care professionals may bundle similar claims and**
66 **claims presenting a common issue of fact to be resolved in a single**
67 **mediation process.**
68 **7. The department of insurance, financial institutions, and**
69 **professional registration may promulgate rules as necessary to**
70 **implement the provisions of this section. Any rule or portion of a rule,**
71 **as that term is defined in section 536.010 that is created under the**
72 **authority delegated in this section shall become effective only if it**
73 **complies with and is subject to all of the provisions of chapter 536, and,**
74 **if applicable, section 536.028. This section and chapter 536 are**
75 **nonseverable and if any of the powers vested with the general assembly**
76 **pursuant to chapter 536, to review, to delay the effective date, or to**
77 **disapprove and annul a rule are subsequently held unconstitutional,**
78 **then the grant of rulemaking authority and any rule proposed or**
79 **adopted after August 28, 2018, shall be invalid and void.**

376.1367. When conducting utilization review or making a benefit
2 determination for emergency services:
3 (1) A health carrier shall cover emergency services necessary to screen
4 and stabilize an enrollee**, as determined by the treating emergency**

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5 **department physician,** and shall not require prior authorization of such
6 services;
7 (2) **Before a health carrier denies payment for an emergency**
8 **service, it shall review the enrollee's medical record regarding the**
9 **emergency medical condition at issue. This review shall be completed**
10 **by a board certified physician who has practiced emergency medicine**
11 **and is actively practicing as a physician licensed under chapter 334. A**
12 **health carrier shall not deny payment for an emergency service based**
13 **predominantly on current procedural terminology or international**
14 **classification of diseases (ICD) codes;**
15 **(3)** Coverage of emergency services shall be subject to applicable
16 co-payments, coinsurance and deductibles;
17 **[**(3)**]** **(4)** When an enrollee receives an emergency service that requires
18 immediate post evaluation or post stabilization services, a health carrier shall
19 provide an authorization decision within sixty minutes of receiving a request; if
20 the authorization decision is not made within **[**thirty**]** **sixty** minutes, such
21 services shall be deemed approved**;**
22 **(5) Payment for all services covered under this section shall be**
23 **paid directly to the health care provider by the health carrier**
24 **regardless of whether the provider is a participating provider**.

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