SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

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HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1617

AN ACT

To repeal sections 191.1145, 208.670, 208.671, 208.673, 208.675, 208.677, 376.427, 376.1350, and 376.1367, RSMo, and to enact in lieu thereof eight new sections relating to reimbursement of health care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 191.1145, 208.670, 208.671, 208.673,
2 208.675, 208.677, 376.427, 376.1350, and 376.1367, RSMo, are
3 repealed and eight new sections enacted in lieu thereof, to be
4 known as sections 191.1145, 208.670, 208.677, 376.427, 376.690,
5 376.1065, 376.1350, and 376.1367, to read as follows:
6 191.1145. 1. As used in sections 191.1145 and 191.1146,
7 the following terms shall mean:
8 (1) "Asynchronous store-and-forward transfer", the
9 collection of a patient's relevant health information and the
10 subsequent transmission of that information from an originating
11 site to a health care provider at a distant site without the
12 patient being present;
13 (2) "Clinical staff", any health care provider licensed in

1 this state;

2 (3) "Distant site", a site at which a health care provider
3 is located while providing health care services by means of
4 telemedicine;

5 (4) "Health care provider", as that term is defined in
6 section 376.1350;

7 (5) "Originating site", a site at which a patient is
8 located at the time health care services are provided to him or
9 her by means of telemedicine. For the purposes of asynchronous
10 store-and-forward transfer, originating site shall also mean the
11 location at which the health care provider transfers information
12 to the distant site;

13 (6) "Telehealth" or "telemedicine", the delivery of health
14 care services by means of information and communication
15 technologies which facilitate the assessment, diagnosis,
16 consultation, treatment, education, care management, and self-
17 management of a patient's health care while such patient is at
18 the originating site and the health care provider is at the
19 distant site. Telehealth or telemedicine shall also include the
20 use of asynchronous store-and-forward technology.

21 2. Any licensed health care provider shall be authorized to
22 provide telehealth services if such services are within the scope
23 of practice for which the health care provider is licensed and
24 are provided with the same standard of care as services provided
25 in person. <u>This section shall not be construed to prohibit a</u>
26 <u>health carrier, as defined in section 376.1350, from reimbursing</u>
27 <u>non-clinical staff for services otherwise allowed by law.</u>

28 3. In order to treat patients in this state through the use

1 of telemedicine or telehealth, health care providers shall be
2 fully licensed to practice in this state and shall be subject to
3 regulation by their respective professional boards.

4 4. Nothing in subsection 3 of this section shall apply to:

5 (1) Informal consultation performed by a health care
6 provider licensed in another state, outside of the context of a
7 contractual relationship, and on an irregular or infrequent basis
8 without the expectation or exchange of direct or indirect
9 compensation;

10 (2) Furnishing of health care services by a health care
11 provider licensed and located in another state in case of an
12 emergency or disaster; provided that, no charge is made for the
13 medical assistance; or

14 (3) Episodic consultation by a health care provider
15 licensed and located in another state who provides such
16 consultation services on request to a physician in this state.

17 5. Nothing in this section shall be construed to alter the
18 scope of practice of any health care provider or to authorize the
19 delivery of health care services in a setting or in a manner not
20 otherwise authorized by the laws of this state.

21 6. No originating site for services or activities provided
22 under this section shall be required to maintain immediate
23 availability of on-site clinical staff during the telehealth
24 services, except as necessary to meet the standard of care for
25 the treatment of the patient's medical condition if such
26 condition is being treated by an eligible health care provider
27 who is not at the originating site, has not previously seen the
28 patient in person in a clinical setting, and is not providing

coverage for a health care provider who has an established relationship with the patient.

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335.

208.670. 1. As used in this section, these terms shall have the following meaning:

(1) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(2) "Distant site", the same meaning as such term is defined in section 191.1145;

(3) "Originating site", the same meaning as such term is defined in section 191.1145;

(4) "Provider", **[**any provider of medical services and mental health services, including all other medical disciplines**]** the same meaning as the term "health care provider" is defined in section 191.1145, and such provider meets all other MO HealthNet eligibility requirements;

[(2)**]** (5) "Telehealth", the same meaning as such term is defined in section 191.1145.

2. **[**Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds.

3. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain participant consent before telehealth services are initiated and to ensure confidentiality of medical information.

4. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.

5. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program**]** The department of social services shall reimburse providers for services provided through telehealth if such providers can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. The department shall not restrict the originating site through rule or payment so long as the provider can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. Payment for services rendered via telehealth shall not depend on any minimum distance requirement between the originating and distant site. Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however,

1 consideration shall also be made for reimbursement to the
2 originating site. Reimbursement for asynchronous store-and-
3 forward may be capped at the reimbursement rate had the service
4 been provided in person.

5 208.677. [1. For purposes of the provision of telehealth
6 services in the MO HealthNet program, the term "originating site"
7 shall mean a telehealth site where the MO HealthNet participant
8 receiving the telehealth service is located for the encounter.
9 The standard of care in the practice of telehealth shall be the
10 same as the standard of care for services provided in person. An
11 originating site shall be one of the following locations:

12 (1) An office of a physician or health care provider;

13 (2) A hospital;

14 (3) A critical access hospital;

15 (4) A rural health clinic;

16 (5) A federally qualified health center;

17 (6) A long-term care facility licensed under chapter 198;

18 (7) A dialysis center;

19 (8) A Missouri state habilitation center or regional
20 office;

21 (9) A community mental health center;

22 (10) A Missouri state mental health facility;

23 (11) A Missouri state facility;

24 (12) A Missouri residential treatment facility licensed by
25 and under contract with the children's division. Facilities
26 shall have multiple campuses and have the ability to adhere to
27 technology requirements. Only Missouri licensed psychiatrists,
28 licensed psychologists, or provisionally licensed psychologists,

and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations;

(13) A comprehensive substance treatment and rehabilitation (CSTAR) program;

(14) A school;

(15) The MO HealthNet recipient's home;

(16) A clinical designated area in a pharmacy; or

(17) A child assessment center as described in section 210.001.

2. If the originating site is a school, the school shall obtain permission from the parent or guardian of any student receiving telehealth services prior to each provision of service.**]** Prior to the provision of telehealth services in a school, the parent or guardian of the child shall provide authorization for the provision of such service. Such authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year.

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

(1) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

(2) "Insured", any person entitled to benefits under a contract of accident and sickness insurance, or medical-payment insurance issued as a supplement to liability insurance but not including any other coverages contained in a liability or a workers' compensation policy, issued by an insurer;

1 (3) "Insurer", any person, reciprocal exchange,
2 interinsurer, fraternal benefit society, health services
3 corporation, self-insured group arrangement to the extent not
4 prohibited by federal law, or any other legal entity engaged in
5 the business of insurance;
6 (4) "Provider", a physician, hospital, dentist, podiatrist,
7 chiropractor, pharmacy, licensed ambulance service, or
8 optometrist, licensed by this state.
9 2. Upon receipt of an assignment of benefits made by the
10 insured to a provider, the insurer shall issue the instrument of
11 payment for a claim for payment for health care services in the
12 name of the provider. All claims shall be paid within thirty
13 days of the receipt by the insurer of all documents reasonably
14 needed to determine the claim.
15 3. Nothing in this section shall preclude an insurer from
16 voluntarily issuing an instrument of payment in the single name
17 of the provider.
18 4. Except as provided in subsection 5 of this section, this
19 section shall not require any insurer, health services
20 corporation, health maintenance corporation or preferred provider
21 organization which directly contracts with certain members of a
22 class of providers for the delivery of health care services to
23 issue payment as provided pursuant to this section to those
24 members of the class which do not have a contract with the
25 insurer.
26 5. When a patient's health benefit plan does not include or
27 require payment to out-of-network providers for all or most
28 covered services, which would otherwise be covered if the patient

1 received such services from a provider in the carrier's network,
2 including, but not limited to, health maintenance organization
3 plans, as such term is defined in section 354.400, or a health
4 benefit plan offered by a carrier consistent with subdivision
5 (19) of section 376.426, payment for all services shall be made
6 directly to the providers when the health carrier has authorized
7 such services to be received from a provider outside the
8 carrier's network.
9 376.690. 1. As used in this section, the following terms
10 shall mean:
11 (1) "Emergency medical condition", the same meaning given
12 to such term in section 376.1350;
13 (2) "Facility", the same meaning given to such term in
14 section 376.1350;
15 (3) "Health care professional", the same meaning given to
16 such term in section 376.1350;
17 (4) "Health carrier", the same meaning given to such term
18 in section 376.1350;
19 (5) "Unanticipated out-of-network care", health care
20 services received by a patient in an in-network facility from an
21 out-of-network health care professional from the time the patient
22 presents with an emergency medical condition until the time the
23 patient is discharged;
24 2. Health care professionals shall send any U.S. Centers of
25 Medicare and Medicaid Services Form 1500, or its successor form,
26 for charges incurred for unanticipated out-of-network care to the
27 patient's health carrier.
28 (1) The health carrier shall offer to pay the health care

1 professional a reasonable reimbursement for unanticipated out-of-
2 network care based on the health care professional's bill.
3 (2) If the health care professional declines the health
4 carrier's initial offer of payment, the health carrier and health
5 care professional shall have sixty days to negotiate in good
6 faith to attempt to determine the reimbursement for the
7 unanticipated out-of-network care.
8 (3) If the health carrier and health care professional do
9 not agree to a reimbursement amount after the sixty day
10 negotiation period has ended, the dispute shall be submitted to
11 the department for a decision through an arbitration process as
12 specified in subsection 4 of this section.
13 (4) To initiate arbitration proceedings, either the health
14 carrier or health care professional shall provide written
15 notification to the director of the department of insurance,
16 financial institutions and professional registration and the
17 other party, indicating their intent to arbitrate the matter and
18 notifying the director of the billed amount and the date and
19 amount of the final offer by each party. A bill for
20 unanticipated out-of-network care may be resolved between the
21 parties at any point prior to the commencement of the arbitration
22 proceedings. Bills may be combined for purposes of arbitration,
23 but only to the extent the bills represent similar circumstances
24 and services provided by the same health care professional.
25 (5) No health care professional shall send a bill to the
26 patient for any difference between the payment received and the
27 payment that would have been received if the payment was based on
28 the rate charged by the health care professional.

3. When unanticipated out-of-network care is provided, the health care professional may bill a patient for no more than the cost-sharing requirements that would be applicable if the services had been provided by an in-network professional.

(1) Cost-sharing requirements shall be based on the payment received by the health care professional as determined under subsection 2 of this section.

(2) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within thirty business days of receiving a bill from the health care professional for services provided.

(3) For purposes of an enrollee's deductible and out-of-pocket maximum, cost-sharing payments to the health care professional shall be treated by the health carrier as though they were paid to an in-network health care professional.

4. The director of the department of insurance, financial institutions and professional registration shall ensure access to an arbitration process when a health care professional and health carrier can not agree to a reasonable reimbursement under subdivision (2) of subsection 2 of this section. In order to ensure access, when notified of a party's intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between, and shall be directly billed to, the health care professional and health carrier. These costs shall include, but shall not be limited to,

1 reasonable time necessary for the arbitrator to review materials
2 in preparation for the arbitration, travel expenses, and
3 reasonable time following the arbitration for drafting of the
4 final decision.
5 5. At the conclusion of the arbitration process, the
6 arbitrator shall issue a final decision, which shall be binding
7 on all parties. The arbitrator shall provide a copy of the final
8 decision to the director. The initial request for arbitration,
9 all correspondence and documents received by the department, and
10 the final arbitration decision shall be considered a confidential
11 record under section 374.071. However, the director may release
12 aggregated summary data regarding the arbitration process. The
13 decision of the arbitrator shall not be considered an agency
14 decision and shall not be considered a contested case, as defined
15 in section 536.010.
16 6. The arbitrator shall determine a dollar amount due under
17 subsection 2 of this section between one hundred twenty percent
18 of the Medicare allowed amount and the seventieth percentile of
19 the usual and customary rate for the unanticipated out-of-network
20 care, as determined by benchmarks from independent nonprofit
21 organizations that are not affiliated with insurance carriers or
22 provider organizations.
23 7. When determining a reasonable reimbursement rate, the
24 arbitrator shall consider the following factors if the health
25 care professional believes the payment offered for the
26 unanticipated out-of-network care does not properly recognize:
27 (1) The health care professional's training, education, or
28 experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. This section shall take effect on January 1, 2019.

10. The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including, but not limited to, procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

376.1065. 1. As used in this section, the following terms shall mean:

(1) "Contracting entity", any health carrier, as defined in section 376.1350, subject to the jurisdiction of the department engaged in the act of contracting with providers for the delivery of dental services, or the selling or assigning of dental network plans to other entities under the jurisdiction of the department;

(2) "Department", department of insurance, financial institutions and professional registration;

(3) "Official notification", written communication by a provider or participating provider to a contracting entity describing such provider's or participating provider's change in contact information or participation status with the contracting entity;

(4) "Participating provider", a provider who has an agreement with a contracting entity to provide dental services with an expectation of receiving payment, other than coinsurance, co-payments, or deductibles, directly or indirectly from such contracting entity;

(5) "Provider", any person licensed under chapter 332.

2. A contracting entity shall, upon official notification, make changes contained in the official notification to their electronic provider material and their next edition of paper material made available to plan members or other potential plan members.

3. The department, when determining the result of a market conduct examination under sections 374.202 to 374.207, shall consider violations of this section by a contracting entity.

1 376.1350. For purposes of sections 376.1350 to 376.1390,
2 the following terms mean:
3 (1) "Adverse determination", a determination by a health
4 carrier or its designee utilization review organization that an
5 admission, availability of care, continued stay or other health
6 care service has been reviewed and, based upon the information
7 provided, does not meet the health carrier's requirements for
8 medical necessity, appropriateness, health care setting, level of
9 care or effectiveness, and the payment for the requested service
10 is therefore denied, reduced or terminated;
11 (2) "Ambulatory review", utilization review of health care
12 services performed or provided in an outpatient setting;
13 (3) "Case management", a coordinated set of activities
14 conducted for individual patient management of serious,
15 complicated, protracted or other health conditions;
16 (4) "Certification", a determination by a health carrier or
17 its designee utilization review organization that an admission,
18 availability of care, continued stay or other health care service
19 has been reviewed and, based on the information provided,
20 satisfies the health carrier's requirements for medical
21 necessity, appropriateness, health care setting, level of care
22 and effectiveness;
23 (5) "Clinical peer", a physician or other health care
24 professional who holds a nonrestricted license in a state of the
25 United States and in the same or similar specialty as typically
26 manages the medical condition, procedure or treatment under
27 review;
28 (6) "Clinical review criteria", the written screening

1 procedures, decision abstracts, clinical protocols and practice
2 guidelines used by the health carrier to determine the necessity
3 and appropriateness of health care services;
4 (7) "Concurrent review", utilization review conducted
5 during a patient's hospital stay or course of treatment;
6 (8) "Covered benefit" or "benefit", a health care service
7 that an enrollee is entitled under the terms of a health benefit
8 plan;
9 (9) "Director", the director of the department of
10 insurance, financial institutions and professional registration;
11 (10) "Discharge planning", the formal process for
12 determining, prior to discharge from a facility, the coordination
13 and management of the care that a patient receives following
14 discharge from a facility;
15 (11) "Drug", any substance prescribed by a licensed health
16 care provider acting within the scope of the provider's license
17 and that is intended for use in the diagnosis, mitigation,
18 treatment or prevention of disease. The term includes only those
19 substances that are approved by the FDA for at least one
20 indication;
21 (12) "Emergency medical condition", the sudden and, at the
22 time, unexpected onset of a health condition that manifests
23 itself by symptoms of sufficient severity, regardless of the
24 final diagnosis that is given, that would lead a prudent lay
25 person, possessing an average knowledge of medicine and health,
26 to believe that immediate medical care is required, which may
27 include, but shall not be limited to:
28 (a) Placing the person's health in significant jeopardy;

1 (b) Serious impairment to a bodily function;
2 (c) Serious dysfunction of any bodily organ or part;
3 (d) Inadequately controlled pain; or
4 (e) With respect to a pregnant woman who is having
5 contractions:
6 a. That there is inadequate time to effect a safe transfer
7 to another hospital before delivery; or
8 b. That transfer to another hospital may pose a threat to
9 the health or safety of the woman or unborn child;
10 (13) "Emergency service", a health care item or service
11 furnished or required to evaluate and treat an emergency medical
12 condition, which may include, but shall not be limited to, health
13 care services that are provided in a licensed hospital's
14 emergency facility by an appropriate provider;
15 (14) "Enrollee", a policyholder, subscriber, covered person
16 or other individual participating in a health benefit plan;
17 (15) "FDA", the federal Food and Drug Administration;
18 (16) "Facility", an institution providing health care
19 services or a health care setting, including but not limited to
20 hospitals and other licensed inpatient centers, ambulatory
21 surgical or treatment centers, skilled nursing centers,
22 residential treatment centers, diagnostic, laboratory and imaging
23 centers, and rehabilitation and other therapeutic health
24 settings;
25 (17) "Grievance", a written complaint submitted by or on
26 behalf of an enrollee regarding the:
27 (a) Availability, delivery or quality of health care
28 services, including a complaint regarding an adverse

1 determination made pursuant to utilization review;

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

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

6 (18) "Health benefit plan", a policy, contract, certificate
7 or agreement entered into, offered or issued by a health carrier
8 to provide, deliver, arrange for, pay for, or reimburse any of
9 the costs of health care services; except that, health benefit
10 plan shall not include any coverage pursuant to liability
11 insurance policy, workers' compensation insurance policy, or
12 medical payments insurance issued as a supplement to a liability
13 policy;

14 (19) "Health care professional", a physician or other
15 health care practitioner licensed, accredited or certified by the
16 state of Missouri to perform specified health services consistent
17 with state law;

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

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

23 (22) "Health carrier", an entity subject to the insurance
24 laws and regulations of this state that contracts or offers to
25 contract to provide, deliver, arrange for, pay for or reimburse
26 any of the costs of health care services, including a sickness
27 and accident insurance company, a health maintenance
28 organization, a nonprofit hospital and health service

1 corporation, or any other entity providing a plan of health
2 insurance, health benefits or health services; except that such
3 plan shall not include any coverage pursuant to a liability
4 insurance policy, workers' compensation insurance policy, or
5 medical payments insurance issued as a supplement to a liability
6 policy;
7 (23) "Health indemnity plan", a health benefit plan that is
8 not a managed care plan;
9 (24) "Managed care plan", a health benefit plan that either
10 requires an enrollee to use, or creates incentives, including
11 financial incentives, for an enrollee to use, health care
12 providers managed, owned, under contract with or employed by the
13 health carrier;
14 (25) "Participating provider", a provider who, under a
15 contract with the health carrier or with its contractor or
16 subcontractor, has agreed to provide health care services to
17 enrollees with an expectation of receiving payment, other than
18 coinsurance, co-payments or deductibles, directly or indirectly
19 from the health carrier;
20 (26) "Peer-reviewed medical literature", a published
21 scientific study in a journal or other publication in which
22 original manuscripts have been published only after having been
23 critically reviewed for scientific accuracy, validity and
24 reliability by unbiased independent experts, and that has been
25 determined by the International Committee of Medical Journal
26 Editors to have met the uniform requirements for manuscripts
27 submitted to biomedical journals or is published in a journal
28 specified by the United States Department of Health and Human

1 Services pursuant to Section 1861(t)(2)(B) of the Social Security
2 Act, as amended, as acceptable peer-reviewed medical literature.
3 Peer-reviewed medical literature shall not include publications
4 or supplements to publications that are sponsored to a
5 significant extent by a pharmaceutical manufacturing company or
6 health carrier;
7 (27) "Person", an individual, a corporation, a partnership,
8 an association, a joint venture, a joint stock company, a trust,
9 an unincorporated organization, any similar entity or any
10 combination of the foregoing;
11 (28) "Prospective review", utilization review conducted
12 prior to an admission or a course of treatment;
13 (29) "Retrospective review", utilization review of medical
14 necessity that is conducted after services have been provided to
15 a patient, but does not include the review of a claim that is
16 limited to an evaluation of reimbursement levels, veracity of
17 documentation, accuracy of coding or adjudication for payment;
18 (30) "Second opinion", an opportunity or requirement to
19 obtain a clinical evaluation by a provider other than the one
20 originally making a recommendation for a proposed health service
21 to assess the clinical necessity and appropriateness of the
22 initial proposed health service;
23 (31) "Stabilize", with respect to an emergency medical
24 condition, that no material deterioration of the condition is
25 likely to result or occur before an individual may be
26 transferred;
27 (32) "Standard reference compendia":
28 (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;

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

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

(1) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee, as determined by the treating emergency department health care provider, and shall not require prior authorization of such services;

(2) Before a health carrier denies payment for an emergency medical service based on the absence of an emergency medical condition, it shall review the enrollee's medical record regarding the emergency medical condition at issue. If a health carrier requests records for a potential denial where emergency services were rendered, the health care provider shall submit the record of the emergency services to the carrier within forty-five days, or the claim shall be subject to section 376.383. The health carrier's review of emergency services shall be completed by a board-certified physician licensed under chapter 334 to

1 practice medicine in this state;

2 (3) Coverage of emergency services shall be subject to

3 applicable co-payments, coinsurance and deductibles;

4 [(3)] (4) When an enrollee receives an emergency service

5 that requires immediate post evaluation or post stabilization

6 services, a health carrier shall provide an authorization

7 decision within sixty minutes of receiving a request; if the

8 authorization decision is not made within **[**thirty**]** sixty minutes,

9 such services shall be deemed approved;

10 (5) When a patient's health benefit plan does not include

11 or require payment to out-of-network health care providers for

12 emergency services, including, but not limited to, health

13 maintenance organization plans, as defined in section 354.400, or

14 a health benefit plan offered by a health carrier consistent with

15 subdivision (19) of section 376.426, payment for all emergency

16 services, as defined in section 376.1350, necessary to screen and

17 stabilize an enrollee shall be paid directly to the health care

18 provider by the health carrier. Additionally, any services

19 authorized by the health carrier for the enrollee once the

20 enrollee is stabilized shall also be paid by the health carrier

21 directly to the health care provider.

22 **[**208.671. 1. As used in this section and section
23 208.673, the following terms shall mean:
24 (1) "Asynchronous store-and-forward", the
25 transfer of a participant's clinically important
26 digital samples, such as still images, videos, audio,
27 text files, and relevant data from an originating site
28 through the use of a camera or similar recording device
29 that stores digital samples that are forwarded via
30 telecommunication to a distant site for consultation by
31 a consulting provider without requiring the
32 simultaneous presence of the participant and the
33 participant's treating provider;
34 (2) "Asynchronous store-and-forward technology",

1 cameras or other recording devices that store images
2 which may be forwarded via telecommunication devices at
3 a later time;
4 (3) "Consultation", a type of evaluation and
5 management service as defined by the most recent
6 edition of the Current Procedural Terminology published
7 annually by the American Medical Association;
8 (4) "Consulting provider", a provider who, upon
9 referral by the treating provider, evaluates a
10 participant and appropriate medical data or images
11 delivered through asynchronous store-and-forward
12 technology. If a consulting provider is unable to
13 render an opinion due to insufficient information, the
14 consulting provider may request additional information
15 to facilitate the rendering of an opinion or decline to
16 render an opinion;
17 (5) "Distant site", the site where a consulting
18 provider is located at the time the consultation
19 service is provided;
20 (6) "Originating site", the site where a MO
21 HealthNet participant receiving services and such
22 participant's treating provider are both physically
23 located;
24 (7) "Provider", any provider of medical, mental
25 health, optometric, or dental health services,
26 including all other medical disciplines, licensed and
27 providing MO HealthNet services who has the authority
28 to refer participants for medical, mental health,
29 optometric, dental, or other health care services
30 within the scope of practice and licensure of the
31 provider;
32 (8) "Telehealth", as that term is defined in
33 section 191.1145;
34 (9) "Treating provider", a provider who:
35 (a) Evaluates a participant;
36 (b) Determines the need for a consultation;
37 (c) Arranges the services of a consulting
38 provider for the purpose of diagnosis and treatment;
39 and
40 (d) Provides or supplements the participant's
41 history and provides pertinent physical examination
42 findings and medical information to the consulting
43 provider.
44 2. The department of social services, in
45 consultation with the departments of mental health and
46 health and senior services, shall promulgate rules
47 governing the use of asynchronous store-and-forward
48 technology in the practice of telehealth in the MO
49 HealthNet program. Such rules shall include, but not
50 be limited to:
51 (1) Appropriate standards for the use of

asynchronous store-and-forward technology in the practice of telehealth;

(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;

(3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion;

(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;

(5) Security and privacy of such digital files;

(6) Participant consent for asynchronous store-and-forward services; and

(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.

Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.

3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. The total payment for both the treating provider and the consulting provider shall not exceed the payment for a face-to-face consultation of the same level.

4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for services provided in person.**]**

[208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in the MO HealthNet program utilizing asynchronous store-and-forward technology.

2. The committee shall be comprised of the following members:

(1) The director of the MO HealthNet division, or the director's designee;

(2) The medical director of the MO HealthNet division;

(3) A representative from a Missouri institution of higher education with expertise in telehealth;

(4) A representative from the Missouri office of primary care and rural health;

(5) Two board-certified specialists licensed to practice medicine in this state;

(6) A representative from a hospital located in this state that utilizes telehealth;

(7) A primary care physician from a federally qualified health center (FQHC) or rural health clinic;

(8) A primary care physician from a rural setting other than from an FQHC or rural health clinic;

(9) A dentist licensed to practice in this state; and

(10) A psychologist, or a physician who specializes in psychiatry, licensed to practice in this state.

3. Members of the committee listed in subdivisions (3) to (10) of subsection 2 of this section shall be appointed by the governor with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, three members to serve two-year terms, and three members to serve a one-year term as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.

4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.

5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor shall make an appointment to become effective immediately for the unexpired term.

6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.**]**

[208.675. For purposes of the provision of

1 telehealth services in the MO HealthNet program, the
2 following individuals, licensed in Missouri, shall be
3 considered eligible health care providers:
4 (1) Physicians, assistant physicians, and
5 physician assistants;
6 (2) Advanced practice registered nurses;
7 (3) Dentists, oral surgeons, and dental
8 hygienists under the supervision of a currently
9 registered and licensed dentist;
10 (4) Psychologists and provisional licensees;
11 (5) Pharmacists;
12 (6) Speech, occupational, or physical therapists;
13 (7) Clinical social workers;
14 (8) Podiatrists;
15 (9) Optometrists;
16 (10) Licensed professional counselors; and
17 (11) Eligible health care providers under
18 subdivisions (1) to (10) of this section practicing in
19 a rural health clinic, federally qualified health
20 center, or community mental health center.**]**