SECOND REGULAR SESSION

SENATE BILL NO. 928

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR ONDER.

Read 1st time January 18, 2018, and ordered printed.

ADRIANE D. CROUSE, Secretary.

5934S.02I

AN ACT

To repeal section 376.1367, RSMo, and to enact in lieu thereof one new section relating to emergency services benefit determinations.

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

Section A. Section 376.1367, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1367, to read as follows:

376.1367. **1.** 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 physician,** and shall not require prior authorization of such services;

(2) **Before a health carrier retrospectively denies payment for an emergency service, it shall review the enrollee's medical record regarding the emergency medical condition at issue. This review shall be completed by a physician who is board certified in emergency medicine and licensed to practice in this state. A health carrier shall not retrospectively deny payment for an emergency service based predominantly on current procedural terminology or international classification of diseases (ICD) codes;**

(3) If a health carrier retrospectively determines the enrollee did not have an emergency medical condition, the health carrier shall have the authority to recapture from the enrollee the amount paid by the health carrier to the health care provider for that emergency service;

(4) Coverage of emergency services shall be subject to applicable

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

co-payments, coinsurance and deductibles;

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

(6) Payment for all services covered under this section shall be paid directly to the health care provider by the health carrier regardless of whether the provider is a participating provider.

2. No health carrier shall reduce payments for evaluation and management services that are otherwise eligible for reimbursement when reported by the same provider on the same day as a procedure, including but not limited to minor surgery.

3. Any contractual provision between a health carrier and a provider which allows for a reduction in reimbursement as specified in subsection 2 of this section shall be void.

4. Payment for all services shall be made directly to the providers when the carrier has authorized the patient to seek such services from a provider outside the carrier's network.

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