FIRST REGULAR SESSION

SENATE BILL NO. 811

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR CARTER.

3094S.01I KRISTINA MARTIN, Secretary

AN ACT

To repeal section 376.1363, RSMo, and to enact in lieu thereof one new section relating to prior authorization for prescribed drugs.

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

Section A. Section 376.1363, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1363, to read as follows:

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For determinations, a health carrier shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the certification, and provide written or electronic

confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without

liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to the health care provider and to any party who received notice of the adverse determination.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. These procedures shall be made available to health care providers on the health carrier's website or provider portal. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

7. Provided the patient is an enrollee of the health benefit plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within forty-five working days of the date the health care provider receives the prior authorization, **or within thirteen months if the prior authorization is for a drug prescribed for management of a chronic condition**.

8. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any in-network deductible or out-of-pocket maximum applicable to the enrollee's health benefit plan.

✓