SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 544

AN ACT

To repeal sections 354.606, 376.383 and 376.406, RSMo 2000, relating to health care services, and to enact in lieu thereof five new sections relating to the same subject.

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

Section A. Sections 354.606, 376.383 and 376.406, RSMo 2000, are repealed and five new sections enacted in lieu thereof, to be known as sections 334.097, 354.606, 376.383, 376.386 and 376.406, to read as follows:

334.097. 1. Physicians shall maintain an adequate, complete and legible written patient record for each patient and may maintain electronic records provided the record keeping format is capable of being printed for review by the state board of registration for the healing arts. An adequate and complete patient record shall include documentation of the following information:

(1) Identification of the patient, including name, birthdate, address and telephone number;

(2) The date or dates the patient was seen;

(3) The current status of the patient, including the reason for the visit;

(4) Observation of pertinent physical findings;

(5) Assessment and clinical impression of diagnosis;

(6) Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;

(7) Any informed consent for office procedures.

2. Patient records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee, for a minimum of seven years from the date of when the last professional service was provided.

3. Any correction, addition or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change.

4. A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician.

5. The board shall not initiate disciplinary action pursuant to subsection 2 of section 334.100 against a licensee solely based on a violation of this section. If the board initiates disciplinary action against the licensee for any reason other than a violation of this section, the board may allege violation of this section as an additional cause for discipline pursuant to subdivision (6) of subsection 2 of section 334.100.

6. The board shall not obtain a patient medical record

without written authorization from the patient to obtain the medical record or the issuance of a subpoena for the patient medical record.

354.606. 1. A health carrier shall establish a mechanism by which the participating provider shall be notified on an ongoing basis of the specific covered health services for which the provider shall be responsible, including any limitations or conditions on services.

2. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for enrollees. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person, other than the health carrier or intermediary, acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement shall not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees. This agreement shall not prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide service exclusively to that health carrier's

enrollees and no others, and an enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider has clearly informed the enrollee that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy; including, but not limited to, collecting from any insurance carrier providing coverage to a covered person."

3. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier's or intermediary's insolvency or other cessation of operations, covered services to enrollees shall continue through the period for which a premium has been paid to the health carrier on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater.

4. The contract provisions satisfying the requirements of subsections 2 and 3 of this section shall:

(1) Be construed in favor of the enrollee;

(2) Survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier; and

(3) Supersede any oral or written contrary agreement between a provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections 2 and 3 of this section.

5. In no event shall a participating provider collect or attempt to collect from an enrollee any money owed to the

provider by the health carrier nor shall a participating provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles. Failure of a health carrier to make timely payment of an amount owed to a provider in accordance with the provider's contract shall constitute an unfair claims settlement practice subject to sections 375.1000 to 375.1018, RSMo.

6. (1) A health carrier shall develop selection standards for participating primary care professionals and each participating health care professional specialty. Such standards shall be in writing and used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner that will:

(a) Allow a health carrier to avoid a high-risk population by excluding a provider because such provider is located in a geographic area that contains a population presenting a risk of higher than average claims, losses or health services utilization; or

(b) Exclude a provider because such provider treats or specializes in treating a population presenting a risk of higher than average claims, losses or health services utilization.

(2) Paragraphs (a) and (b) of subdivision (1) of this subsection shall not be construed to prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier developed in compliance with sections 354.600 to 354.636.

(3) The provisions of sections 354.600 to 354.636 shall not require a health carrier, its intermediaries or the provider networks with which it contracts, to employ specific providers or types of providers, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

7. A health carrier shall file its selection standards for participating providers with the director. A health carrier shall also file any subsequent changes to its selection standards with the director. The selection standards shall be made available to licensed health care providers.

8. A health carrier shall notify a participating provider of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

9. No contract between a health carrier and a provider for the delivery of health care service, entered into or renewed after August 28, 2001, shall require the mandatory use of a hospitalist. For purposes of this subsection, "hospitalist" means a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to that participating provider at the end of hospitalization.

[9.**]** 10. A health carrier shall not offer an inducement

under the managed care plan to a provider to provide less than medically necessary services to an enrollee.

[10.**]** 11. A health carrier shall not prohibit a participating provider from advocating in good faith on behalf of enrollees within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

[11.**]** 12. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

[12.**]** 13. The rights and responsibilities of a provider under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

[13.**]** 14. A health carrier shall be responsible for ensuring that a participating provider furnishes covered benefits to all enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care service.

[14.**]** 15. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments or deductibles from enrollees pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations

for noncovered services.

[15.**]** 16. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare.

[16.**]** 17. A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether a person is covered by the carrier.

[17.**]** 18. A health carrier shall not discriminate between health care professionals when selecting such professionals for enrollment in the network or when referring enrollees for health care services to be provided by such health care professional who is acting within the scope of his professional license.

[18.**]** 19. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

[19.**]** 20. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or sections 354.600 to 354.636.

376.383. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health **[**insurer**]** carrier as defined in section **[**376.806, any nonprofit health service plan and any health maintenance organization**]** 376.1350.

2. Within forty-five days after receipt of a claim for reimbursement **[**from a person entitled to reimbursement**]** or within twenty-five days after receipt of an electronic claim for

reimbursement for a health care service provided in this state as defined in section 376.1350, a health [insurer, nonprofit health service plan or health maintenance organization] carrier shall pay the claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the [insurer, nonprofit health service plan or health maintenance organization] health carrier refuses to reimburse all or part of the claim and the reason for the refusal; [or]

(2) Until April 1, 2002, that additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information that is necessary; or

(3) On or after April 1, 2002, that additional information is necessary to determine if all or part of the claim will be reimbursed and a complete description of all specific additional information that is necessary to process the entire claim.

3. The date of receipt of the claim shall be three days after the postmarked date or instantly upon receipt by any health carrier or its agents if filed electronically. A confirmation of receipt must be sent within ten days for claims received non-electronically.

4. If [an insurer, nonprofit health service plan or health maintenance organization] a health carrier fails to comply with subsection 2 of this section, the [insurer, nonprofit health service plan or health maintenance organization] health carrier shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of

one percent. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregated amount reaches five dollars.

[4.**]** 5. Within ten days after the day on which all additional information is received by **[**an insurer, nonprofit health service plan or health maintenance organization**]** a health carrier, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

[An insurer, nonprofit health service plan or health maintenance organization**]** A health carrier that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

[5. A provider who is paid interest under this section shall pay the proportionate amount of said interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.**]**

6. **[**This section shall become effective April 1, 1999.**]** In addition to other remedies provided by law, a person who has filed a claim for reimbursement for a health care service, as defined in section 376.1350, may file a civil action against the health carrier for any violation of this section; provided that

such person may not file a civil action until the tenth day following the receipt by the health carrier of a certified letter notifying the health carrier of such person's intention to file a civil action pursuant to this section. Such notice must include the information previously submitted on the claim for reimbursement. No civil action may be filed on any claim and interest paid within the ten-day grace period. If the court finds that a violation of this section has occurred, the court shall award to a prevailing plaintiff a penalty of forty to eighty dollars per day beginning ten days following the date that interest pursuant to this section first becomes due, in addition to the claimed reimbursement, interest and reasonable attorney fees.

376.386. 1. For purposes of this section, "health care provider" or "provider" means a health care professional or facility, and "health carrier" means the same as such term is defined in section 376.1350. Any health carrier shall:

(1) Permit providers to file confirmation numbers of certified services and claims in the same manner or format;

(2) Permit providers to file claims for reimbursement for a period of up to one year following the provision of a health care service;

(3) Effective January 1, 2003, accept claims for reimbursement from health care providers that are filed electronically. Effective January 1, 2003, all claims for reimbursement filed with health carriers by health care providers that are submitted electronically shall be filed in a form and format specified by the department of insurance. The department

of insurance shall promulgate rules specifying the form and format governing such electronic claims submission consistent with federal administrative simplifications standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996;

(4) Issue within twenty-four hours, for all claims filed electronically, confirmation of receiving a claim for reimbursement;

(5) When processing claims, accept all codes, including modifiers, that are included within the physician's current procedural terminology of the American Medical Association, as amended; the Health Care Financing Administration's common procedure coding system, as amended; the International Classification of Diseases 9th Revision Clinical Modification system, as amended; Diagnosis Related Group coding, as amended; and any additional procedure, diagnosis and treatment codes approved by the department of insurance. The department of insurance shall promulgate rules for the implementation of such standard codes and the approval of additional procedure, diagnosis and treatment codes; and

(6) During contract negotiations with providers and upon delivery of the final contract, provide a current fee schedule for provider reimbursement for all covered services for which the health care professional is contracted to provide and forward to the provider, at least thirty days in advance of the effective date of such modifications, all modifications to such fee schedule.

2. No health carrier shall request a refund or offset

against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the provider.

3. All health carriers shall provide access on the Internet to a current provider directory.

4. A health carrier shall inform an enrollee when the health carrier denies coverage of a health care service requested to be provided to such enrollee. The health carrier shall explain such denial of coverage in plain language that is easy for a layperson to understand.

5. Effective July 1, 2002, a health carrier shall issue to each enrollee an enrollee card which includes a telephone number for the plan, prescription drug information and a brief description of the enrollee's type of health care plan. Such description shall include, but not be limited to, terms such as preferred provider organization, point of service, health maintenance organization or indemnity plan. Such enrollee card shall be reissued upon any change in the enrollee's benefits or coverage that impacts the information included on the card.

6. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2001, shall be invalid and void.

376.406. 1. All [individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, and all self-insured group health benefit plans, of any type or description,] health benefit plans, as defined in section 376.1350, which provide coverage for a family member of [the insured or subscriber] an enrollee shall, as to such family member's coverage, also provide that the health [insurance] benefits applicable for children shall be payable with respect to a newly born child of the [insured or subscriber] enrollee from the moment of birth.

2. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the [policy or contract] health benefit plan may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the [insurer or nonprofit service or indemnity corporation] health carrier within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one day period. If an application or other form of enrollment is required in order to continue coverage beyond the thirty-one-day period after the date of birth and the enrollee has notified the health carrier of the birth, either

orally or in writing, the health carrier shall, upon notification, provide the enrollee with all forms and instructions necessary to enroll the newly born child and shall allow the enrollee an additional ten days from the date the forms and instructions are provided in which to enroll the newly born child.

4. The requirements of this section shall apply to all [insurance policies and subscriber contracts] health benefit plans delivered or issued for delivery in this state [more than one hundred twenty days after August 13, 1974] on or after August 28, 2001.

5. For the purposes of this section, any review, renewal, extension, or continuation of any [plan, policy, or contract] health benefit plan or of any of the terms, premiums, or subscriptions of the [plan, policy, or contract] health benefit plan shall constitute a new delivery or issuance for delivery of the [plan, policy or contract] health benefit plan.

6. As used in this section, the terms "health benefit plan", "health carrier" and "enrollee" shall have the same meaning as defined in section 376.1350.