SECOND REGULAR SESSION

HOUSE BILL NO. 1570

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES STEFANICK (Sponsor), PEARCE, COOPER (155), PORTWOOD, NIEVES, HOBBS, SEIGFREID, STEVENSON, SCHAAF, HARRIS (23), PAGE, JONES AND SAGER (Co-sponsors).

Read 1st time February 25, 2004, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

4052L.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto two new sections relating to provider contracts with health carriers.

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

Section A. Chapter 376, RSMo, is amended by adding thereto two new sections, to be known as sections 376.386 and 376.387, to read as follows:

376.386. 1. No health carrier or health benefit plan, including preferred provider organizations, independent physician associations, or any other entity that contracts with health care providers for health care services, shall change or attempt to change any code submitted by the provider for health care services without the express written permission of the physician unless:

(1) Such change is pursuant to correct coding initiative (CCI) guidelines related to current procedural terminology (c.p.t.) guidelines; and

(2) The change is based on the examination of the patient record to determine the services provided by the provider. Nothing in this section shall prohibit a health carrier or health benefit plan from requesting additional information under section 376.383.

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

3. No contract of a health carrier or health benefit plan, including preferred provider organizations, independent physician associations, or any other entity that contracts with providers for health care services shall fail to include or attach at the time such contract is presented to the provider for execution:

(1) The codes, including code modifications, that represent the specific covered

health care services the provider can submit on health care claims and that the health carrier or health benefit plan shall provide compensation, remuneration, or reimbursement for. The code and code modifiers shall refer to the most recent American Medical Association code book or other recognized codes as adopted and used in the Medicare and Medicaid programs;

(2) The fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid which are applicable to the provider or to the range of health care services reasonably expected to be delivered by the provider on a routine basis; and

(3) All material addenda, schedules, and exhibits thereto, and any policies applicable to the provider or the range of health care services reasonably expected to be delivered by the provider under the contract.

4. No amendment to any provider contract, nor any new or amendment to any addenda, schedule, exhibit, or policy thereto, applicable to the provider shall be effective as to the provider until sixty days after the provider has been provided with the applicable portion of such new or proposed amendment.

5. Nothing in this section shall prohibit health carriers or health benefit plans and providers from complying with the provisions of sections 376.383 to 376.384.

6. This section shall become effective January 1, 2005.

376.387. 1. No health carrier, as defined in section 376.1350, shall require a participating provider, as defined in section 376.1350, to pay a fee, commission, rebate, or other form of compensation as a condition for or prerequisite to becoming or remaining a participating provider.

2. This section shall apply to all contracts entered into or renewed after the effective date of this section, but in no case will any such fee, commission, rebate, or other form of compensation be payable after August 28, 2004.