SECOND REGULAR SESSION

HOUSE BILL NO. 1944

103RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HRUZA.

5555H.01I JOSEPH ENGLER, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto two new sections relating to health insurance claims settlement practices, with penalty provisions.

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 376.1245 and 376.1580, to read as follows:

376.1245. 1. As used in this section, the following terms mean:

(1) "Anesthesia time", the period during which an anesthesia practitioner is present with the patient, starting when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ending when the anesthesia practitioner is no longer furnishing anesthesia services to the patient because the patient may be placed safely under postoperative or postanesthesia care. The term "anesthesia time" includes, if counted by the anesthesia practitioner, blocks of time around an interruption in anesthesia time provided the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption;

(2) "Anesthesia time units", time units recognized with appropriate time intervals that do not exceed fifteen minutes in length for each interval and that, taken together, represent the total anesthesia time for a particular anesthesia service;

(3) "Excepted benefit plan", the same meaning given to the term in section 376.998;

(4) "Health benefit plan", the same meaning given to the term in section 376.1350. The term "health benefit plan" shall also include MO HealthNet, the

EXPLANATION — Matter enclosed in bold-faced brackets **[**~~thus~~**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

children's health insurance program authorized under chapter 208, the Missouri consolidated health care plan established under chapter 103, and any other state-sponsored health insurance program;

(5) "Health carrier", the same meaning given to the term in section 376.1350. The term "health carrier" shall also include the MO HealthNet division and any Medicaid managed care organization as defined in section 208.431;

(6) "Payment of anesthesia services", an amount paid for anesthesia services:

(a) Determined by using prevailing medical coding and billing standards in the professional medical billing community, such as the Current Procedural Terminology code book published by the American Medical Association, the Medicare Claims Processing Manual, or guidance from nationally recognized anesthesia organizations; and

(b) Calculated as the product obtained by multiplying the following together:

a. The sum of the base units for the appropriate medical code plus anesthesia time units; and

b. An anesthesia conversion factor that is defined in the individual contract between the health carrier or health benefit plan and the anesthesia practitioner or group.

2. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that imposes a time limit for the payment of anesthesia services provided during a medical or surgical procedure.

3. No health carrier or health benefit plan shall establish, implement, or enforce any policy, practice, or procedure that restricts or excludes all anesthesia time in calculating the payment of anesthesia services.

4. Excepted benefit plans shall be subject to the requirements of this section.

376.1580. 1. As used in this section, the following terms mean:

(1) "Claim", a claim for reimbursement for a health care service provided by a physician;

(2) "Claim Adjustment Reason Code", a code in the list of Claim Adjustment Reason Codes that provides the reason for a financial adjustment specific to a particular claim or health care service referenced in the transmitted Accredited Standards Committee (ASC) X12 835 standard transaction adopted by the United States Department of Health and Human Services under 45 CFR 162.1602;

(3) "Director", the director of the department of commerce and insurance;

(4) "Downcoding", the unilateral alteration by a health carrier of the level of evaluation and management service code or other service code submitted on a claim, resulting in a lower payment on the claim;

(5) "Health care service", the same meaning given to the term in section 376.1350;

(6) "Health carrier", the same meaning given to the term in section 376.1350. The term "health carrier" shall also include a third-party administrator or other payer responsible for adjudicating claims;

(7) "Remittance Advice Remark Code", a code in the list of Remittance Advice Remark Codes that provides supplemental information about a financial adjustment indicated by a Claim Adjustment Reason Code or information about remittance processing.

2. (1) A health carrier shall not use an automated process, system, or tool to downcode a claim. An automated tool includes, but is not limited to, the use of artificial intelligence.

(2) Any downcoding decision shall be made by a physician who is licensed in this state and shares the same specialty as the treating physician. The physician reviewer shall perform a documented review of the clinical information supporting the billed health care service.

3. A health carrier shall not downcode a claim based solely on the reported diagnosis code.

4. A health carrier that downcodes a claim shall notify the treating physician using the appropriate Claim Adjustment Reason Code and Remittance Advice Remark Code to clearly indicate that the claim has been downcoded and provide:

(1) The specific reason for the downcoding, including reference to the clinical criteria used to justify the downcoding;

(2) The original and revised health care service codes and payment amounts;

(3) The National Provider Identifier of the physician who is responsible for the downcoding decision as well as the physician's credentials, board certifications, and areas of specialty expertise and training; and

(4) A notice of the right to appeal as described in subsection 5 of this section.

5. (1) Health carriers shall provide physicians with a clear and accessible process for appealing downcoded claims including, but not limited to, a written or electronic notice detailing how to initiate an appeal, contact information for the individual managing the appeal, reasonable timelines for submission of an appeal that are not less than one hundred eighty days, and timelines for adjudication of an appeal.

(2) Physicians shall have the right to appeal in batches of similar claims involving substantially similar downcoding issues without restriction.

6. (1) A health carrier shall not use downcoding practices in a targeted or discriminatory manner against physicians who routinely treat patients with complex or chronic conditions.

(2) Any pattern or practice of discriminatory downcoding shall be subject to enforcement actions by the director including, but not limited to, civil penalties, restitution, or suspension of the health carrier's license to operate in this state.

7. (1) If the director determines that a health carrier has engaged, is engaging, or has taken a substantial step toward engaging in an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued in accordance with this section or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued in accordance with this section, the director may issue such administrative orders as authorized under section 374.046. A curative order under section 374.046 may include an order to reprocess claims downcoded in violation of this section and to pay any accrued interest on the claims paid.

(2) If the director believes that a health carrier has engaged, is engaging, or has taken a substantial step toward engaging in an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued in accordance with this section or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued in accordance with this section, the director may maintain a civil action for relief authorized under section 374.048.

(3) A violation of this section is a level four violation under section 374.049.

8. The director may promulgate all necessary rules and regulations for the administration of this section. 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, 2026, shall be invalid and void.

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