

FIRST REGULAR SESSION

HOUSE BILL NO. 867

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE JONES (50).

2045H.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.164, RSMo, and to enact in lieu thereof one new section relating to prior authorization for providers of medical assistance benefits.

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

Section A. Section 208.164, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.164, to read as follows:

208.164. 1. As used in this section, unless the context clearly requires otherwise, the following terms mean:

(1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered. The decision to impose any of the sanctions authorized in this section shall be made by the director of the department, following a determination of demonstrable need or accepted medical practice made in consultation with medical or other health care professionals, or qualified peer review teams;

(2) "Department", the department of social services;

(3) "Excessive use", the act, by a person eligible for services under a contract or provider agreement between the department of social services or its divisions and a provider, of seeking and/or obtaining medical assistance benefits from a number of like providers and in quantities which exceed the levels that are considered medically necessary by current medical practices and standards for the eligible person's needs;

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.

19 (4) "Fraud", a known false representation, including the concealment of a material fact
20 that provider knew or should have known through the usual conduct of his profession or
21 occupation, upon which the provider claims reimbursement under the terms and conditions of
22 a contract or provider agreement and the policies pertaining to such contract or provider
23 agreement of the department or its divisions in carrying out the providing of services, or under
24 any approved state plan authorized by the federal Social Security Act;

25 (5) "Health plan", a group of services provided to recipients of medical assistance
26 benefits by providers under a contract with the department;

27 (6) "Medical assistance benefits", those benefits authorized to be provided by sections
28 208.152 and 208.162;

29 (7) "Prior authorization", approval to a provider to perform a service or services for an
30 eligible person required by the department or its divisions in advance of the actual service being
31 provided or approved for a recipient to receive a service or services from a provider, required by
32 the department or its designated division in advance of the actual service or services being
33 received;

34 (8) "Provider", any person, partnership, corporation, not-for-profit corporation,
35 professional corporation, or other business entity that enters into a contract or provider agreement
36 with the department or its divisions for the purpose of providing services to eligible persons, and
37 obtaining from the department or its divisions reimbursement therefor;

38 (9) "Recipient", a person who is eligible to receive medical assistance benefits allocated
39 through the department;

40 (10) "Service", the specific function, act, successive acts, benefits, continuing benefits,
41 requested by an eligible person or provided by the provider under contract with the department
42 or its divisions.

43 2. The department or its divisions shall have the authority to suspend, revoke, or cancel
44 any contract or provider agreement or refuse to enter into a new contract or provider agreement
45 with any provider where it is determined the provider has committed or allowed its agents,
46 servants, or employees to commit acts defined as abuse or fraud in this section.

47 3. The department or its divisions shall have the authority to impose prior authorization
48 as defined in this section:

49 (1) When it has reasonable cause to believe a provider or recipient has knowingly
50 followed a course of conduct which is defined as abuse or fraud or excessive use by this section;
51 or

52 (2) When it determines by rule that prior authorization is reasonable for a specified
53 service or procedure.

54 4. If a provider or recipient reports to the department or its divisions the name or names
55 of providers or recipients who, based upon their personal knowledge has reasonable cause to
56 believe an act or acts are being committed which are defined as abuse, fraud or excessive use by

57 this section, such report shall be confidential and the reporter's name shall not be divulged to
58 anyone by the department or any of its divisions, except at a judicial proceeding upon a proper
59 protective order being entered by the court.

60 5. Payments for services under any contract or provider agreement between the
61 department or its divisions and a provider may be withheld by the department or its divisions
62 from the provider for acts or omissions defined as abuse or fraud by this section, until such time
63 as an agreement between the parties is reached or the dispute is adjudicated under the laws of this
64 state.

65 6. The department or its designated division shall have the authority to review all cases
66 and claim records for any recipient of public assistance benefits and to determine from these
67 records if the recipient has, as defined in this section, committed excessive use of such services
68 by seeking or obtaining services from a number of like providers of services and in quantities
69 which exceed the levels considered necessary by current medical or health care professional
70 practice standards and policies of the program.

71 7. The department or its designated division shall have the authority with respect to
72 recipients of medical assistance benefits who have committed excessive use to limit or restrict
73 the use of the recipient's Medicaid identification card to designated providers and for designated
74 services; the actual method by which such restrictions are imposed shall be at the discretion of
75 the department of social services or its designated division.

76 8. The department or its designated division shall have the authority with respect to any
77 recipient of medical assistance benefits whose use has been restricted under subsection 7 of this
78 section and who obtains or seeks to obtain medical assistance benefits from a provider other than
79 one of the providers for designated services to terminate medical assistance benefits as defined
80 by this chapter, where allowed by the provisions of the federal Social Security Act.

81 9. The department or its designated division shall have the authority with respect to any
82 provider who knowingly allows a recipient to violate subsection 7 of this section or who fails to
83 report a known violation of subsection 7 of this section to the department of social services or
84 its designated division to terminate or otherwise sanction such provider's status as a participant
85 in the medical assistance program. Any person making such a report shall not be civilly liable
86 when the report is made in good faith.

87 **10. Nothing in this section shall prohibit providers from using clinical decision**
88 **support tools as an alternative to prior authorization to determine the clinical**
89 **appropriateness of services or procedures.**

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