MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representatives Mims, Felsher

To: Public Health and Human Services

HOUSE BILL NO. 780

1 AN ACT TO CREATE NEW SECTIONS 83-41-501 THROUGH 83-41-517,
2 MISSISSIPPI CODE OF 1972, TO AUTHORIZE AN EXEMPTION FROM PRIOR
3 AUTHORIZATION REQUIREMENTS BY HEALTH INSURERS FOR PHYSICIANS AND
4 OTHER PROVIDERS WHO PROVIDE CERTAIN HEALTH CARE SERVICES; TO
5 PROVIDE THAT A HEALTH INSURER THAT USES A PRIOR AUTHORIZATION
6 PROCESS FOR HEALTH CARE SERVICES MAY NOT REQUIRE A PHYSICIAN OR
7 OTHER PROVIDER TO OBTAIN PRIOR AUTHORIZATION FOR A PARTICULAR
8 HEALTH CARE SERVICE IF, IN THE MOST RECENT SIX-MONTH EVALUATION
9 PERIOD, THE HEALTH INSURER HAS APPROVED OR WOULD HAVE APPROVED NOT
10 LESS THAN 90 PERCENT OF THE PRIOR AUTHORIZATION REQUESTS SUBMITTED
11 FOR THE PARTICULAR HEALTH CARE SERVICE; TO AUTHORIZE A HEALTH
12 INSURER TO RESCIND AN EXEMPTION FROM PRIOR AUTHORIZATION
13 REQUIREMENTS ONLY IF THE HEALTH INSURER MAKES A DETERMINATION, ON
14 THE BASIS OF A RETROSPECTIVE REVIEW OF A RANDOM SAMPLE OF CLAIMS
15 SUBMITTED BY THE PHYSICIAN OR OTHER PROVIDER DURING THE MOST
16 RECENT EVALUATION PERIOD, THAT LESS THAN 90 PERCENT OF THE CLAIMS
17 FOR THE PARTICULAR HEALTH CARE SERVICE MET THE MEDICAL NECESSITY
18 CRITERIA THAT WOULD HAVE BEEN USED BY THE HEALTH INSURER WHEN
19 CONDUCTING PRIOR AUTHORIZATION REVIEW FOR THE PARTICULAR HEALTH
20 CARE SERVICE DURING THE RELEVANT EVALUATION PERIOD; TO PROVIDE
21 THAT SUCH A DETERMINATION MUST BE MADE BY AN INDIVIDUAL LICENSED
22 TO PRACTICE MEDICINE IN THIS STATE; TO PROVIDE THAT A PHYSICIAN OR
23 OTHER PROVIDER HAS A RIGHT TO A REVIEW OF AN ADVERSE DETERMINATION
24 REGARDING A DENIAL OR RESCISSION OF A PRIOR AUTHORIZATION
25 EXEMPTION AND THAT THE REVIEW MUST BE CONDUCTED BY AN ACCREDITED
26 INDEPENDENT REVIEW ORGANIZATION; TO PROVIDE THAT A HEALTH INSURER
27 SHALL PAY FOR ANY APPEAL OR INDEPENDENT REVIEW OF AN ADVERSE
28 DETERMINATION REGARDING A PRIOR AUTHORIZATION EXEMPTION REQUESTED
29 BY A PHYSICIAN OR OTHER PROVIDER; TO PROVIDE THAT A HEALTH INSURER
30 IS BOUND BY AN APPEAL OR INDEPENDENT REVIEW DETERMINATION THAT
31 DOES NOT AFFIRM THE DETERMINATION MADE BY THE HEALTH INSURER TO
32 RESCIND OR DENY A PRIOR AUTHORIZATION EXEMPTION; TO PROVIDE THAT A
33 HEALTH INSURER SHALL NOT DENY OR REDUCE PAYMENT TO A PHYSICIAN OR
34 OTHER PROVIDER FOR A HEALTH CARE SERVICE FOR WHICH THE PHYSICIAN

35 OR OTHER PROVIDER HAS QUALIFIED FOR AN EXEMPTION FROM PRIOR
36 AUTHORIZATION REQUIREMENTS BASED ON MEDICAL NECESSITY OR
37 APPROPRIATENESS OF CARE, UNLESS THE PHYSICIAN OR OTHER
38 PROVIDER KNOWINGLY AND MATERIALLY MISREPRESENTED THE HEALTH CARE
39 SERVICE IN A REQUEST FOR PAYMENT SUBMITTED TO THE HEALTH INSURER
40 WITH THE SPECIFIC INTENT TO DECEIVE AND OBTAIN AN UNLAWFUL PAYMENT
41 FROM THE HEALTH INSURER, OR FAILED TO SUBSTANTIALLY PERFORM THE
42 HEALTH CARE SERVICE; TO AMEND SECTIONS 41-83-9, 41-83-31,
43 73-23-35, 83-9-6.3, 83-9-32, 83-9-353, 83-41-409 AND 83-51-15,
44 MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PROVISIONS OF THIS
45 ACT; AND FOR RELATED PURPOSES.

46 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

47 **SECTION 1.** The following shall be codified as Section
48 83-41-501, Mississippi Code of 1972:

49 83-41-501. (1) **Legislative findings and intent.** The
50 Legislature finds and declares that certain prior authorization
51 practices employed within the insurance industry have become an
52 integral part of the policy relationship between the insurer and
53 insured and, accordingly, should be regulated in the manner
54 provided for in this article to reduce administrative burdens and
55 promote access to safe and timely care by providers of health care
56 services.

57 (2) **Definitions.** As used in this article, the following
58 terms have the meanings as defined in this section, unless the
59 context otherwise requires:

60 (a) "Health care service" means a service provided to
61 an individual to prevent, alleviate, cure or heal human illness or
62 injury. The term includes:

63 (i) Pharmaceutical services;

64 (ii) Medical, chiropractic or dental care;

65 (iii) Hospitalization; or

66 (iv) Care or services incidental to the foregoing
67 services.
68 (b) "Health insurer" means any health insurance
69 company, nonprofit hospital and medical service corporation,
70 health maintenance organization, preferred provider organization,
71 managed care organization, pharmacy benefit manager, and, to the
72 extent permitted under federal law, any administrator of an
73 insured, self-insured or publicly funded health care benefit plan
74 offered by public and private entities, and other parties that are
75 by statute, contract or agreement, legally responsible for payment
76 of a claim for a health care item or service.
77 (c) "Health insurance plan" means any health insurance
78 policy or health insurance plan offered by a health insurer, and
79 includes the State and School Employees Health Insurance Plan and
80 any other public health care assistance program offered or
81 administered by the state or any political subdivision or
82 instrumentality of the state.
83 (d) "Physician" means an individual licensed to
84 practice medicine in this state.
85 (e) "Prior authorization" means a determination by a
86 health insurer or person contracting with a health insurer or
87 health insurance plan that health care services proposed to be
88 provided to a patient are medically necessary and appropriate.
89 (f) "Provider" means an individual, other than a
90 physician, who is licensed or otherwise authorized to provide a

91 health care service in this state, including, but not limited to,
92 a chiropractor, registered nurse, pharmacist or optometrist. The
93 term "provider" does not include a hospital.

94 **SECTION 2.** The following shall be codified as Section
95 83-41-503, Mississippi Code of 1972:

96 83-41-503. **Applicability of article.** This article applies
97 only to:

98 (a) A health insurance plan offered by a health
99 insurer, except that this article does not apply to:

100 (i) The Mississippi Children's Health Insurance
101 Program, authorized by Chapter 86, Title 41, Mississippi Code of
102 1972; or

103 (ii) The state Medicaid program, including the
104 Medicaid managed care program, coordinated care program,
105 coordinated care organization program or health maintenance
106 organization program, authorized by Article 3, Chapter 13, Title
107 43, Mississippi Code of 1972;

108 (b) A managed care plan offered by a managed care
109 entity under Article 9, Chapter 41 of Title 83, Mississippi Code
110 of 1972; and

111 (c) A person who contracts with a health insurer or
112 health insurance plan to issue prior authorization determinations
113 or perform the functions described in this article, including, but
114 not limited to, a private review agent, as defined by Section
115 41-83-1(b).

116 **SECTION 3.** The following shall be codified as Section
117 83-41-505, Mississippi Code of 1972:

118 83-41-505. **Exemption from prior authorization requirements
119 for physicians and providers providing certain health care
120 services.** (1) A health insurer that uses a prior authorization
121 process for health care services may not require a physician or a
122 provider to obtain prior authorization for a particular health
123 care service if, in the most recent six-month evaluation period,
124 as described by subsection (2) of this section, the health insurer
125 has approved or would have approved not less than ninety percent
126 (90%) of the prior authorization requests submitted by the
127 physician or provider for the particular health care service.

128 (2) Except as provided by subsection (3) of this section, a
129 health insurer shall evaluate whether a physician or provider
130 qualifies for an exemption from prior authorization requirements
131 under subsection (1) of this section once every six (6) months.

132 (3) A health insurer may continue an exemption under
133 subsection (1) of this section without evaluating whether the
134 physician or provider qualifies for the exemption under subsection
135 (1) of this section for a particular evaluation period.

136 (4) A physician or provider is not required to request an
137 exemption under subsection (1) of this section to qualify for the
138 exemption.

139 **SECTION 4.** The following shall be codified as Section
140 83-41-507, Mississippi Code of 1972:

141 <u>83-41-507.</u> **Duration of prior authorization exemption.** (1)
142 A physician's or provider's exemption from prior authorization
143 requirements under Section 83-41-505 remains in effect until:
144 (a) The thirtieth day after the date the health insurer
145 notifies the physician or provider of the health insurer's
146 determination to rescind the exemption under Section 83-41-505, if
147 the physician or provider does not appeal the health insurer's
148 determination or request review by an independent review
149 organization as provided for in Section 83-41-511; or
150 (b) If the physician or provider appeals the
151 determination, the fifth day after the date that the independent
152 review organization, as provided for in section 83-41-511 and
153 83-41-513, affirms the health insurer's determination to rescind
154 the exemption.
155 (2) If a health insurer does not finalize a rescission
156 determination as specified in subsection (1) of this section, then
157 the physician or provider is considered to have met the criteria
158 under Section 83-41-505 to continue to qualify for the exemption.
159 **SECTION 5.** The following shall be codified as Section
160 83-41-509, Mississippi Code of 1972:
161 <u>83-41-509.</u> **Denial or rescission of prior authorization**
162 **exemption.** (1) A health insurer may rescind an exemption from
163 prior authorization requirements under Section 83-41-505 only:
164 (a) During January or June of each year;

165 (b) If the health insurer makes a determination, on the
166 basis of a retrospective review of a random sample of not fewer
167 than ten (10) and not more than twenty (20) claims submitted by
168 the physician or provider during the most recent evaluation period
169 described by Section 83-41-505(2), that less than ninety percent
170 (90%) of the claims for the particular health care service met the
171 medical necessity criteria that would have been used by the health
172 insurer when conducting prior authorization review for the
173 particular health care service during the relevant evaluation
174 period; and
175 (c) If the health insurer complies with other
176 applicable requirements specified in this section, including:
177 (i) Notifying the physician or provider not less
178 than twenty-five (25) days before the proposed rescission is to
179 take effect; and
180 (ii) Providing with the notice to the physician or
181 provider the sample information used to make the determination and
182 a plain language explanation of how the physician or provider may
183 appeal and seek an independent review of the determination.
184 (2) A determination made under subsection (1)(b) of this
185 section shall be made by an individual licensed to practice
186 medicine in this state. For a determination made under subsection
187 (1)(b) of this section with respect to a physician, the
188 determination shall be made by an individual licensed to practice
189 medicine in this state who is also certified by a board recognized

190 by the American Board of Medical Specialties in the same or
191 similar specialty as the physician.
192 (3) A health insurer may deny an exemption from prior
193 authorization requirements under Section 83-41-505 only if:
194 (a) The physician or provider does not have the
195 exemption at the time of the relevant evaluation period; and
196 (b) The health insurer provides the physician or
197 provider with actual statistics and data for the relevant prior
198 authorization request evaluation period and detailed information
199 sufficient to demonstrate that the physician or provider does not
200 meet the criteria for an exemption from prior authorization
201 requirements for the particular health care service under Section
202 83-41-505.
203 **SECTION 6.** The following shall be codified as Section
204 83-41-511, Mississippi Code of 1972:
205 83-41-511. **Independent review of exemption determination.**
206 (1) A physician or provider has a right to a review of an
207 adverse determination regarding a denial or rescission of a prior
208 authorization exemption and that it be conducted by an accredited
209 independent review organization. A health insurer shall not
210 require a physician or provider to engage in an internal appeal
211 process before requesting a review by an independent review
212 organization under this section.

213 (2) A health insurer shall pay for any appeal or independent
214 review of an adverse determination regarding a prior authorization
215 exemption requested under this section.

216 (3) An independent review organization shall complete an
217 expedited review and render a decision with regard to an adverse
218 determination regarding a prior authorization exemption not later
219 than the fifth working day after the date a physician or provider
220 files the request for a review under this section.

221 (4) A physician or provider may request that the independent
222 review organization consider another random sample of not fewer
223 than ten (10) and not more than twenty (20) claims submitted to
224 the health insurer by the physician or provider during the
225 relevant evaluation period for the relevant health care service as
226 part of its review. If the physician or provider makes a request
227 under this subsection, the independent review organization shall
228 base its determination on the medical necessity of claims reviewed
229 by the health insurer under Section 83-41-509 and reviewed under
230 this subsection.

231 **SECTION 7.** The following shall be codified as Section
232 83-41-513, Mississippi Code of 1972:

233 83-41-513. **Effect of appeal or independent review**
234 **determination.** (1) A health insurer is bound by an appeal or
235 independent review determination that does not affirm the
236 determination made by the health insurer to rescind or deny a
237 prior authorization exemption.

238 (2) A health insurer shall not retroactively deny a health
239 care service on the basis of a rescission of an exemption, even if
240 the health insurer's determination to rescind the prior
241 authorization exemption is affirmed by an independent review
242 organization.

243 (3) If a determination of a prior authorization exemption
244 made by the health insurer is overturned on review by an
245 independent review organization, the health insurer:

246 (a) Shall not attempt to rescind the exemption before
247 the end of the next evaluation period that occurs; and

248 (b) May only rescind the exemption after the health
249 insurer complies with Sections 83-41-509 and 83-41-511.

250 **SECTION 8.** The following shall be codified as Section
251 83-41-515, Mississippi Code of 1972:

252 83-41-515. **Eligibility for prior authorization exemption**
253 **following finalized exemption rescission or denial.** After a final
254 determination or review affirming the rescission or denial of an
255 exemption for a specific health care service under Section
256 83-41-505, a physician or provider is eligible for consideration
257 of an exemption for the same health care service after the
258 six-month evaluation period that follows the evaluation period
259 that formed the basis of the rescission or denial of an exemption
260 and a physician or provider is not required to request an
261 exemption to qualify for an exemption.

262 **SECTION 9.** The following shall be codified as Section
263 83-41-517, Mississippi Code of 1972:

264 83-41-517. **Effect of prior authorization exemption.** (1) A
265 health insurer shall not deny or reduce payment to a physician or
266 provider for a health care service for which the physician or
267 provider has qualified for an exemption from prior authorization
268 requirements under Section 83-41-505 based on medical necessity or
269 appropriateness of care unless the physician or provider:

270 (a) Knowingly and materially misrepresented the health
271 care service in a request for payment submitted to the health
272 insurer with the specific intent to deceive and obtain an unlawful
273 payment from the health insurer; or

274 (b) Failed to substantially perform the health care
275 service.

276 (2) A health insurer shall not conduct a retrospective
277 review of a health care service subject to an exemption except:

278 (a) To determine if the physician or provider still
279 qualifies for an exemption under this article; or

280 (b) If the health insurer has a reasonable cause to
281 suspect a basis for denial exists under subsection (1) of this
282 section.

283 (3) For a retrospective review described by subsection (2)
284 of this section, nothing in this article shall be construed to
285 modify or otherwise affect:

286 (a) The requirements under or application of Chapter
287 83, Title 41, Mississippi Code of 1972, including any timeframes
288 specified by that chapter; or
289 (b) Any other applicable law, except to prescribe the
290 only circumstances under which:
291 (i) A retrospective utilization review may occur
292 as specified by subsection (2)(b) of this section; or
293 (ii) Payment may be denied or reduced as specified
294 by subsection (1) of this section.
295 (4) Not later than five (5) working days after qualifying
296 for an exemption from prior authorization requirements under
297 Section 83-41-505, a health insurer shall provide to a physician
298 or provider a notice that includes:
299 (a) A statement that the physician or provider
300 qualifies for an exemption from prior authorization requirements
301 under Section 83-41-505;
302 (b) A list of the health care services and health
303 insurance plans to which the exemption applies; and
304 (c) A statement of the duration of the exemption.
305 (5) If a physician or provider submits a prior authorization
306 request for a health care service for which the physician or
307 provider qualifies for an exemption from prior authorization
308 requirements under Section 83-41-505, the health insurer shall
309 promptly provide a notice to the physician or provider that
310 includes:

311 (a) The information described by subsection (4) of this
312 section; and
313 (b) A notification of the health insurer's payment
314 requirements.
315 (6) Nothing in this article shall be construed to:
316 (a) Authorize a physician or provider to provide a
317 health care service outside the scope of the physician's or
318 provider's applicable professional license; or
319 (b) Require a health insurer to pay for a health care
320 service described by paragraph (a) of this subsection that is
321 performed in violation of the laws of this state.
322 **SECTION 10.** Sections 1 through 9 of this act shall be
323 codified as a new Article 11 in Chapter 41, Title 83, Mississippi
324 Code of 1972.
325 **SECTION 11.** Section 41-83-9, Mississippi Code of 1972, is
326 amended as follows:
327 41-83-9. In conjunction with the application, the private
328 review agent shall submit information that the department requires
329 including:
330 (a) A utilization review plan that includes:
331 (i) A description of review criteria, standards
332 and procedures to be used in evaluating proposed or delivered
333 hospital and medical care and the provisions by which patients,
334 physicians or hospitals may seek reconsideration or appeal of
335 adverse decisions by the private review agent; and

336 <u>(ii) Policies and procedures to exempt from prior</u>
337 <u>authorization requirements physicians or providers providing</u>
338 <u>certain health care services, pursuant to the provisions of</u>
339 <u>Article 11, Chapter 41, Title 83, Mississippi Code of 1972;</u>
340 (b) The type and qualifications of the personnel either
341 employed or under contract to perform the utilization review;
342 (c) The procedures and policies to insure that a
343 representative of the private review agent is reasonably
344 accessible to patients and providers at all times in this state;
345 (d) The policies and procedures to insure that all
346 applicable state and federal laws to protect the confidentiality
347 of individual medical records are followed;
348 (e) A copy of the materials designed to inform
349 applicable patients and providers of the requirements of the
350 utilization review plan; and
351 (f) A list of the third party payors for which the
352 private review agent is performing utilization review in this
353 state.
354 **SECTION 12.** Section 41-83-31, Mississippi Code of 1972, is
355 amended as follows:
356 41-83-31. Any program of utilization review with regard to
357 hospital, medical or other health care services provided in this
358 state shall comply with the following:
359 (a) No determination adverse to a patient or to any
360 affected health care provider shall be made on any question

361 relating to the necessity or justification for any form of
362 hospital, medical or other health care services without prior
363 evaluation and concurrence in the adverse determination by a
364 physician licensed to practice in Mississippi and, in the case of
365 health care services furnished by a physician, certified by a
366 board recognized by the American Board of Medical Specialties in
367 the same or similar specialty as the physician. The physician who
368 made the adverse determination shall provide the health care
369 provider who ordered, requested, provided or is to provide the
370 health care service a reasonable opportunity to discuss the
371 reasons for any adverse determination *** * *** before an adverse
372 determination is issued by a private review agent. Adverse
373 determination by a physician shall not be grounds for any
374 disciplinary action against the physician by the State Board of
375 Medical Licensure.

376 (b) Any determination regarding hospital, medical or
377 other health care services rendered or to be rendered to a patient
378 which may result in a denial of third-party reimbursement or a
379 denial of precertification for that service shall include the
380 evaluation, findings and concurrence of a physician *** * *** licensed
381 to practice medicine in this state and, in the case of a health
382 care service rendered by a physician, certified by a board
383 recognized by the American Board of Medical Specialties in the
384 same or similar specialty as the physician, to make a final

385 determination that care rendered or to be rendered was, is, or may
386 be medically inappropriate.
387 (c) The requirement in this section that the physician
388 who makes the evaluation and concurrence in the adverse
389 determination must be licensed to practice in Mississippi shall
390 not apply to the Comprehensive Health Insurance Risk Pool
391 Association or its policyholders and shall not apply to any
392 utilization review company which reviews fewer than ten (10)
393 persons residing in the State of Mississippi.
394 **SECTION 13.** Section 73-23-35, Mississippi Code of 1972, is
395 amended as follows:
396 73-23-35. (1) A person, corporation, association or
397 business entity shall not use in connection with that person's or
398 party's name or the name or activity of the business the words
399 "physical therapy," "physical therapist," "physiotherapy,"
400 "physiotherapist," "registered physical therapist," "doctor of
401 physical therapy," "physical therapist assistant," the letters
402 "PT," "DPT," "LPT," "RPT," "PTA," "LPTA," and/or any other words,
403 abbreviations, or insignia indicating or implying directly or
404 indirectly that physical therapy is provided or supplied unless
405 such services are provided by or under the direction of a physical
406 therapist or physical therapist assistant, as the case may be,
407 with a valid and current license issued pursuant to this chapter
408 or with the privilege to practice. It shall be unlawful to employ

409 an unlicensed physical therapist or physical therapist assistant
410 to provide physical therapy services.

411 (2) The board shall aid the state's attorneys of the various
412 counties in the enforcement of the provisions of this chapter and
413 the prosecution of any violations thereof. In addition to the
414 criminal penalties provided by this chapter, the civil remedy of
415 injunction shall be available to restrain and enjoin violations of
416 any provisions of this chapter without proof of actual damages
417 sustained by any person. For purposes of this chapter, the board,
418 in seeking an injunction, need only show that the defendant
419 violated subsection (1) of this section to establish irreparable
420 injury or a likelihood of a continuation of the violation.

421 (3) A physical therapist licensed under this chapter or
422 privileged to practice shall not perform physical therapy services
423 without a prescription or referral from a person licensed as a
424 physician, dentist, osteopath, podiatrist, chiropractor, physician
425 assistant or nurse practitioner. However, a physical therapist
426 licensed under this chapter or privileged to practice may perform
427 physical therapy services without a prescription or referral under
428 the following circumstances:

429 (a) To children with a diagnosed developmental
430 disability pursuant to the patient's plan of care.

431 (b) As part of a home health care agency pursuant to
432 the patient's plan of care.

433 (c) To a patient in a nursing home pursuant to the
434 patient's plan of care.
435 (d) Related to conditioning or to providing education
436 or activities in a wellness setting for the purpose of injury
437 prevention, reduction of stress or promotion of fitness.
438 (e) (i) To an individual for a previously diagnosed
439 condition or conditions for which physical therapy services are
440 appropriate after informing the health care provider rendering the
441 diagnosis. The diagnosis must have been made within the previous
442 one hundred eighty (180) days. The physical therapist shall
443 provide the health care provider who rendered the diagnosis with a
444 plan of care for physical therapy services within the first
445 fifteen (15) days of physical therapy intervention.
446 (ii) Nothing in this chapter shall create
447 liability of any kind for the health care provider rendering the
448 diagnosis under this paragraph (e) for a condition, illness or
449 injury that manifested itself after the diagnosis, or for any
450 alleged damages as a result of physical therapy services performed
451 without a prescription or referral from a person licensed as a
452 physician, dentist, osteopath, podiatrist, chiropractor, physician
453 assistant or nurse practitioner, the diagnosis and/or prescription
454 for physical therapy services having been rendered with reasonable
455 care.
456 (4) Physical therapy services performed without a
457 prescription or referral from a person licensed as a physician,

458 dentist, osteopath, podiatrist, chiropractor, physician assistant
459 or nurse practitioner shall not be construed to mandate coverage
460 for physical therapy services under any health care plan,
461 insurance policy, or workers' compensation or circumvent any
462 requirement for preauthorization of services in accordance with
463 any health care plan, insurance policy or workers' compensation.
464 (5) Nothing in this section shall restrict the Division of
465 Medicaid from setting rules and regulations regarding the coverage
466 of physical therapy services and nothing in this section shall
467 amend or change the Division of Medicaid's schedule of benefits,
468 exclusions and/or limitations related to physical therapy services
469 as determined by state or federal regulations and state and
470 federal law.
471 (6) Nothing in this section shall require a physician,
472 physical therapist or other provider to obtain preauthorization or
473 prior authorization for physical therapy services or other health
474 care services described in this section if the physician, physical
475 therapist or other provider is exempt from the requirement of
476 obtaining a prior authorization pursuant to the authority of
477 Article 11, Chapter 41, Title 83, Mississippi Code of 1972.
478 **SECTION 14.** Section 83-9-6.3, Mississippi Code of 1972, is
479 amended as follows:
480 83-9-6.3. (1) As used in this section:
481 (a) "Health benefit plan" means services consisting of
482 medical care, provided directly, through insurance or

483 reimbursement, or otherwise, and including items and services paid
484 for as medical care under any hospital or medical service policy
485 or certificate, hospital or medical service plan contract,
486 preferred provider organization, or health maintenance
487 organization contract offered by a health insurance issuer. The
488 term "health benefit plan" includes the Medicaid fee-for-service
489 program and any managed care program, coordinated care program,
490 coordinated care organization program or health maintenance
491 organization program implemented by the Division of Medicaid.
492 (b) "Health insurance issuer" means any entity that
493 offers health insurance coverage through a health benefit plan,
494 policy, or certificate of insurance subject to state law that
495 regulates the business of insurance. "Health insurance issuer"
496 also includes a health maintenance organization, as defined and
497 regulated under Section 83-41-301 et seq., and includes the
498 Division of Medicaid for the services provided by fee-for-service
499 and through any managed care program, coordinated care program,
500 coordinated care organization program or health maintenance
501 organization program implemented by the division.
502 (c) "Prior authorization" means a utilization
503 management criterion used to seek permission or waiver of a drug
504 to be covered under a health benefit plan that provides
505 prescription drug benefits.

506 (d) "Prior authorization form" means a standardized,
507 uniform application developed by a health insurance issuer for the
508 purpose of obtaining prior authorization.
509 (2) Notwithstanding any other provision of law to the
510 contrary, in order to establish uniformity in the submission of
511 prior authorization forms, on or after January 1, 2014, a health
512 insurance issuer shall use only a single, standardized prior
513 authorization form for obtaining any prior authorization for
514 prescription drug benefits. The form shall not exceed two (2)
515 pages in length, excluding any instructions or guiding
516 documentation. The form shall also be made available
517 electronically, and the prescribing provider may submit the
518 completed form electronically to the health benefit plan.
519 Additionally, the health insurance issuer shall submit its prior
520 authorization forms to the Mississippi Department of Insurance to
521 be kept on file on or after January 1, 2014. A copy of any
522 subsequent replacements or modifications of a health insurance
523 issuer's prior authorization form shall be filed with the
524 Mississippi Department of Insurance within fifteen (15) days prior
525 to use or implementation of such replacements or modifications.
526 (3) A health insurance issuer shall respond within two (2)
527 business days upon receipt of a completed prior authorization
528 request from a prescribing provider that was submitted using the
529 standardized prior authorization form required by subsection (2)
530 of this section.

531 <u>(4) Nothing in this section shall require a prescribing</u>
532 <u>provider to obtain a prior authorization if the prescribing</u>
533 <u>provider is exempt from the requirement of obtaining a prior</u>
534 <u>authorization pursuant to the authority of Article 11, Chapter 41,</u>
535 <u>Title 83, Mississippi Code of 1972.</u>

536 **SECTION 15.** Section 83-9-32, Mississippi Code of 1972, is
537 amended as follows:

538 83-9-32. <u>(1)</u> Every hospital, health or medical expenses
539 insurance policy, hospital or medical service contract, health
540 maintenance organization and preferred provider organization that
541 is delivered or issued for delivery in this state and otherwise
542 provides anesthesia benefits shall offer benefits for anesthesia
543 and for associated facility charges when the mental or physical
544 condition of the child or mentally handicapped adult requires
545 dental treatment to be rendered under physician-supervised general
546 anesthesia in a hospital setting, surgical center or dental
547 office. This coverage shall be offered on an optional basis, and
548 each primary insured must accept or reject such coverage in
549 writing and accept responsibility for premium payment.

550 <u>(2)</u> An insurer may require prior authorization for the
551 anesthesia and associated facility charges for dental care
552 procedures in the same manner that prior authorization is required
553 for treatment of other medical conditions under general
554 anesthesia. An insurer may require review for medical necessity
555 and may limit payment of facility charges to certified facilities

556 in the same manner that medical review is required and payment of
557 facility charges is limited for other services. The benefit
558 provided by this coverage shall be subject to the same annual
559 deductibles or coinsurance established for all other covered
560 benefits within a given policy, plan or contract. Private
561 third-party payers may not reduce or eliminate coverage due to
562 these requirements.

563 (3) A dentist shall consider the Indications for General
564 Anesthesia as published in the reference manual of the American
565 Academy of Pediatric Dentistry as utilization standards for
566 determining whether performing dental procedures necessary to
567 treat the particular condition or conditions of the patient under
568 general anesthesia constitutes appropriate treatment.

569 (4) The provisions of this section shall apply to anesthesia
570 services provided by oral and maxillofacial surgeons as permitted
571 by the Mississippi State Board of Dental Examiners.

572 (5) The provisions of this section shall not apply to
573 treatment rendered for temporal mandibular joint (TMJ) disorders.

574 (6) Nothing in this section shall require a physician,
575 dentist or other provider to obtain prior authorization for a
576 health care service described in this section if the dentist or
577 other provider is exempt from the requirement of obtaining a prior
578 authorization pursuant to the authority of Article 11, Chapter 41,
579 Title 83, Mississippi Code of 1972.

580 **SECTION 16.** Section 83-9-353, Mississippi Code of 1972, is
581 amended as follows:
582 83-9-353. (1) As used in this section:
583 (a) "Employee benefit plan" means any plan, fund or
584 program established or maintained by an employer or by an employee
585 organization, or both, to the extent that such plan, fund or
586 program was established or is maintained for the purpose of
587 providing for its participants or their beneficiaries, through the
588 purchase of insurance or otherwise, medical, surgical, hospital
589 care or other benefits.
590 (b) "Health insurance plan" means any health insurance
591 policy or health benefit plan offered by a health insurer, and
592 includes the State and School Employees Health Insurance Plan and
593 any other public health care assistance program offered or
594 administered by the state or any political subdivision or
595 instrumentality of the state. The term does not include policies
596 or plans providing coverage for specified disease or other limited
597 benefit coverage.
598 (c) "Health insurer" means any health insurance
599 company, nonprofit hospital and medical service corporation,
600 health maintenance organization, preferred provider organization,
601 managed care organization, pharmacy benefit manager, and, to the
602 extent permitted under federal law, any administrator of an
603 insured, self-insured or publicly funded health care benefit plan
604 offered by public and private entities, and other parties that are

605 by statute, contract, or agreement, legally responsible for
606 payment of a claim for a health care item or service.
607 (d) "Store-and-forward telemedicine services" means the
608 use of asynchronous computer-based communication between a patient
609 and a consulting provider or a referring health care provider and
610 a medical specialist at a distant site for the purpose of
611 diagnostic and therapeutic assistance in the care of patients who
612 otherwise have no access to specialty care. Store-and-forward
613 telemedicine services involve the transferring of medical data
614 from one (1) site to another through the use of a camera or
615 similar device that records (stores) an image that is sent
616 (forwarded) via telecommunication to another site for
617 consultation.
618 (e) "Remote patient monitoring services" means the
619 delivery of home health services using telecommunications
620 technology to enhance the delivery of home health care, including:
621 (i) Monitoring of clinical patient data such as
622 weight, blood pressure, pulse, pulse oximetry and other
623 condition-specific data, such as blood glucose;
624 (ii) Medication adherence monitoring; and
625 (iii) Interactive video conferencing with or
626 without digital image upload as needed.
627 (f) "Mediation adherence management services" means the
628 monitoring of a patient's conformance with the clinician's
629 medication plan with respect to timing, dosing and frequency of

630 medication-taking through electronic transmission of data in a
631 home telemonitoring program.
632 (2) Store-and-forward telemedicine services allow a health
633 care provider trained and licensed in his or her given specialty
634 to review forwarded images and patient history in order to provide
635 diagnostic and therapeutic assistance in the care of the patient
636 without the patient being present in real time. Treatment
637 recommendations made via electronic means shall be held to the
638 same standards of appropriate practice as those in traditional
639 provider-patient setting.
640 (3) Any patient receiving medical care by store-and-forward
641 telemedicine services shall be notified of the right to receive
642 interactive communication with the distant specialist health care
643 provider and shall receive an interactive communication with the
644 distant specialist upon request. If requested, communication with
645 the distant specialist may occur at the time of the consultation
646 or within thirty (30) days of the patient's notification of the
647 request of the consultation. Telemedicine networks unable to
648 offer the interactive consultation shall not be reimbursed for
649 store-and-forward telemedicine services.
650 (4) Remote patient monitoring services aim to allow more
651 people to remain at home or in other residential settings and to
652 improve the quality and cost of their care, including prevention
653 of more costly care. Remote patient monitoring services via
654 telehealth aim to coordinate primary, acute, behavioral and

655 long-term social service needs for high-need, high-cost patients.
656 Specific patient criteria must be met in order for reimbursement
657 to occur.

658 (5) Qualifying patients for remote patient monitoring
659 services must meet all the following criteria:

660 (a) Be diagnosed, in the last eighteen (18) months,
661 with one or more chronic conditions, as defined by the Centers for
662 Medicare and Medicaid Services (CMS), which include, but are not
663 limited to, sickle cell, mental health, asthma, diabetes, and
664 heart disease; and

665 (b) The patient's health care provider recommends
666 disease management services via remote patient monitoring.

667 (6) A remote patient monitoring prior authorization request
668 form may be required for approval of telemonitoring services
669 unless the physician or provider is exempt from the requirement of
670 obtaining a prior authorization pursuant to the authority of
671 Article 11, Chapter 41, Title 83, Mississippi Code of 1972. If
672 prior authorization is required, the request form must include the
673 following:

674 (a) An order for home telemonitoring services, signed
675 and dated by the prescribing physician;

676 (b) A plan of care, signed and dated by the prescribing
677 physician, that includes telemonitoring transmission frequency and
678 duration of monitoring requested;

679 (c) The client's diagnosis and risk factors that
680 qualify the client for home telemonitoring services;
681 (d) Attestation that the client is sufficiently
682 cognitively intact and able to operate the equipment or has a
683 willing and able person to assist in completing electronic
684 transmission of data; and
685 (e) Attestation that the client is not receiving
686 duplicative services via disease management services.
687 (7) The entity that will provide the remote monitoring must
688 be a Mississippi-based entity and have protocols in place to
689 address all of the following:
690 (a) Authentication and authorization of users;
691 (b) A mechanism for monitoring, tracking and responding
692 to changes in a client's clinical condition;
693 (c) A standard of acceptable and unacceptable
694 parameters for client's clinical parameters, which can be adjusted
695 based on the client's condition;
696 (d) How monitoring staff will respond to abnormal
697 parameters for client's vital signs, symptoms and/or lab results;
698 (e) The monitoring, tracking and responding to changes
699 in client's clinical condition;
700 (f) The process for notifying the prescribing physician
701 for significant changes in the client's clinical signs and
702 symptoms;

703 (g) The prevention of unauthorized access to the system
704 or information;
705 (h) System security, including the integrity of
706 information that is collected, program integrity and system
707 integrity;
708 (i) Information storage, maintenance and transmission;
709 (j) Synchronization and verification of patient profile
710 data; and
711 (k) Notification of the client's discharge from remote
712 patient monitoring services or the de-installation of the remote
713 patient monitoring unit.
714 (8) The telemonitoring equipment must:
715 (a) Be capable of monitoring any data parameters in the
716 plan of care; and
717 (b) Be a FDA Class II hospital-grade medical device.
718 (9) Monitoring of the client's data shall not be duplicated
719 by another provider.
720 (10) To receive payment for the delivery of remote patient
721 monitoring services via telehealth, the service must involve:
722 (a) An assessment, problem identification, and
723 evaluation that includes:
724 (i) Assessment and monitoring of clinical data
725 including, but not limited to, appropriate vital signs, pain
726 levels and other biometric measures specified in the plan of care,

727 and also includes assessment of response to previous changes in
728 the plan of care; and
729 (ii) Detection of condition changes based on the
730 telemedicine encounter that may indicate the need for a change in
731 the plan of care.
732 (b) Implementation of a management plan through one or
733 more of the following:
734 (i) Teaching regarding medication management as
735 appropriate based on the telemedicine findings for that encounter;
736 (ii) Teaching regarding other interventions as
737 appropriate to both the patient and the caregiver;
738 (iii) Management and evaluation of the plan of
739 care including changes in visit frequency or addition of other
740 skilled services;
741 (iv) Coordination of care with the ordering health
742 care provider regarding telemedicine findings;
743 (v) Coordination and referral to other medical
744 providers as needed; and
745 (vi) Referral for an in-person visit or the
746 emergency room as needed.
747 (11) The telemedicine equipment and network used for remote
748 patient monitoring services should meet the following
749 requirements:
750 (a) Comply with applicable standards of the United
751 States Food and Drug Administration;

752 (b) Telehealth equipment be maintained in good repair
753 and free from safety hazards;
754 (c) Telehealth equipment be new or sanitized before
755 installation in the patient's home setting;
756 (d) Accommodate non-English language options; and
757 (e) Have 24/7 technical and clinical support services
758 available for the patient user.
759 (12) All health insurance and employee benefit plans in this
760 state must provide coverage and reimbursement for the asynchronous
761 telemedicine services of store-and-forward telemedicine services
762 and remote patient monitoring services based on the criteria set
763 out in this section. Store-and-forward telemedicine services
764 shall be reimbursed to the same extent that the services would be
765 covered if they were provided through in-person consultation.
766 (13) Remote patient monitoring services shall include
767 reimbursement for a daily monitoring rate at a minimum of Ten
768 Dollars ($10.00) per day each month and Sixteen Dollars ($16.00)
769 per day when medication adherence management services are
770 included, not to exceed thirty-one (31) days per month. These
771 reimbursement rates are only eligible to Mississippi-based
772 telehealth programs affiliated with a Mississippi health care
773 facility.
774 (14) A one-time telehealth installation/training fee for
775 remote patient monitoring services will also be reimbursed at a
776 minimum rate of Fifty Dollars ($50.00) per patient, with a maximum

777 of two (2) installation/training fees/calendar year. These
778 reimbursement rates are only eligible to Mississippi-based
779 telehealth programs affiliated with a Mississippi health care
780 facility.

781 (15) No geographic restrictions shall be placed on the
782 delivery of telemedicine services in the home setting other than
783 requiring the patient reside within the State of Mississippi.

784 (16) Health care providers seeking reimbursement for
785 store-and-forward telemedicine services must be licensed
786 Mississippi providers that are affiliated with an established
787 Mississippi health care facility in order to qualify for
788 reimbursement of telemedicine services in the state. If a service
789 is not available in Mississippi, then a health insurance or
790 employee benefit plan may decide to allow a non-Mississippi-based
791 provider who is licensed to practice in Mississippi reimbursement
792 for those services.

793 (17) A health insurance or employee benefit plan may charge
794 a deductible, co-payment, or coinsurance for a health care service
795 provided through store-and-forward telemedicine services or remote
796 patient monitoring services so long as it does not exceed the
797 deductible, co-payment, or coinsurance applicable to an in-person
798 consultation.

799 (18) A health insurance or employee benefit plan may limit
800 coverage to health care providers in a telemedicine network
801 approved by the plan.

802 (19) Nothing in this section shall be construed to prohibit
803 a health insurance or employee benefit plan from providing
804 coverage for only those services that are medically necessary,
805 subject to the terms and conditions of the covered person's
806 policy.
807 (20) In a claim for the services provided, the appropriate
808 procedure code for the covered service shall be included with the
809 appropriate modifier indicating telemedicine services were used.
810 A "GQ" modifier is required for asynchronous telemedicine services
811 such as store-and-forward and remote patient monitoring.
812 (21) The originating site is eligible to receive a facility
813 fee, but facility fees are not payable to the distant site.
814 **SECTION 17.** Section 83-41-409, Mississippi Code of 1972, is
815 amended as follows:
816 83-41-409. In order to be certified and recertified under
817 this article, a managed care plan shall:
818 (a) Provide enrollees or other applicants with written
819 information on the terms and conditions of coverage in easily
820 understandable language including, but not limited to, information
821 on the following:
822 (i) Coverage provisions, benefits, limitations,
823 exclusions and restrictions on the use of any providers of care;
824 (ii) Summary of utilization review and quality
825 assurance policies; and

826 (iii) Enrollee financial responsibility for
827 copayments, deductibles and payments for out-of-plan services or
828 supplies;
829 (b) Demonstrate that its provider network has providers
830 of sufficient number throughout the service area to assure
831 reasonable access to care with minimum inconvenience by plan
832 enrollees;
833 (c) File a summary of the plan credentialing criteria
834 and process and policies with the State Department of Insurance to
835 be available upon request;
836 (d) Provide a participating provider with a copy of
837 his/her individual profile if economic or practice profiles, or
838 both, are used in the credentialing process upon request;
839 (e) When any provider application for participation is
840 denied or contract is terminated, the reasons for denial or
841 termination shall be reviewed by the managed care plan upon the
842 request of the provider; *** * * ***
843 (f) Establish procedures to ensure that all applicable
844 state and federal laws designed to protect the confidentiality of
845 medical records are followed *** * * ***; and
846 (g) Establish and comply with policies and procedures
847 to exempt from prior authorization requirements physicians or
848 providers providing certain health care services, pursuant to the
849 provisions of Article 11, Chapter 41, Title 83, Mississippi Code
850 of 1972.

851 **SECTION 18.** Section 83-51-15, Mississippi Code of 1972, is
852 amended as follows:
853 83-51-15. (1) (a) A dental service contractor or a
854 contract of dental insurance shall establish and maintain appeal
855 procedures for any claim by a dentist or a subscriber that is
856 denied based upon lack of medical necessity.
857 (b) Any denial shall be based upon a determination by a
858 dentist who holds a nonrestricted license issued in the United
859 States in the same or an appropriate specialty that typically
860 manages the dental condition, procedure, or treatment under
861 review.
862 (c) Subsequent to an initial denial, the licensed
863 dentist making the adverse determination shall not be an employee
864 of the dental service contractor or dental insurer.
865 (d) Any written communication to an insured or a
866 dentist that includes or pertains to a denial of benefits for all
867 or part of a claim on the basis of a lack of medical necessity
868 shall include the name, applicable specialty designation, license
869 number together with state of issuance, and the email address of
870 the licensed dentist making the adverse determination.
871 (2) (a) For the purposes of this subsection, a "prior
872 authorization" shall mean any predetermination, prior
873 authorization or similar authorization that is verifiable, whether
874 through issuance of letter, facsimile, e-mail or similar means,
875 indicating that a specific procedure is, or multiple procedures

876 are, covered under the patient's plan and reimbursable at a
877 specific amount, subject to applicable coinsurance and
878 deductibles, and issued in response to a request submitted by a
879 dentist using a prescribed format.
880 (b) A dental service contractor shall not deny any
881 claim subsequently submitted for procedures specifically included
882 in a prior authorization unless at least one (1) of the following
883 circumstances applies for each procedure denied:
884 (i) Benefit limitations such as annual maximums
885 and frequency limitations not applicable at the time of prior
886 authorization are reached due to utilization subsequent to
887 issuance of the prior authorization;
888 (ii) The documentation for the claim provided by
889 the person submitting the claim clearly fails to support the claim
890 as originally authorized;
891 (iii) If, subsequent to the issuance of the prior
892 authorization, new procedures are provided to the patient or a
893 change in the patient's condition occurs such that the prior
894 authorized procedure would no longer be considered medically
895 necessary, based on the prevailing standard of care;
896 (iv) If, subsequent to the issuance of the prior
897 authorization, new procedures are provided to the patient or a
898 change in the patient's condition occurs such that the prior
899 authorized procedure would at that time require disapproval
900 pursuant to the terms and conditions for coverage under the

901 patient's plan in effect at the time the prior authorization was
902 issued; or
903 (v) The dental service contractor's denial is
904 because of one (1) of the following:
905 1. Another payor is responsible for the
906 payment;
907 2. The dentist has already been paid for the
908 procedures identified on the claim;
909 3. The claim was submitted fraudulently or
910 the prior authorization was based in whole or material part on
911 erroneous information provided to the dental service contractor by
912 the dentist, patient, or other person not related to the carrier;
913 or
914 4. The person receiving the procedure was not
915 eligible to receive the procedure on the date of service and the
916 dental service contractor did not know, and with the exercise of
917 reasonable care could not have known, of the person's eligibility
918 status.
919 (c) A dental service contractor shall not require any
920 information be submitted for a prior authorization request that
921 would not be required for submission of a claim.
922 (d) A dental service contractor shall issue a prior
923 authorization within thirty (30) days of the date a request is
924 submitted by a dentist.

925 (e) The provisions of subsection (1) of this section
926 shall apply to any denial of a claim pursuant to paragraph (b) of
927 this subsection for a procedure included in a prior authorization.
928 (3) A contractor shall not recoup a claim solely due to a
929 patient's loss of coverage or ineligibility if, at the time of
930 treatment, the contractor erroneously confirms coverage and
931 eligibility, but had sufficient information available to it
932 indicating that the patient was no longer covered or was
933 ineligible for coverage.
934 (4) Nothing in this section shall require a dentist or other
935 provider to obtain prior authorization for a health care service
936 described in this section if the dentist or other provider is
937 exempt from the requirement of obtaining a prior authorization
938 pursuant to the authority of Article 11, Chapter 41, Title 83,
939 Mississippi Code of 1972.
940 **SECTION 19.** Article 11, Chapter 41, Title 83, Mississippi
941 Code of 1972, as added by this act, applies only to a request for
942 prior authorization of a health care service made on or after
943 January 1, 2023. A request for prior authorization of health care
944 services made before January 1, 2023, is governed by the law as it
945 existed immediately before the effective date of this act, and
946 that law is continued in effect for that purpose.
947 **SECTION 20.** This act shall take effect and be in force from
948 and after its passage.

ST: Health insurers; authorize exemption from prior authorization requirements of for health care providers if certain criteria are met.