MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Representative Deweese

To: Public Health and Human Services

HOUSE BILL NO. 866

AN ACT TO CREATE NEW SECTIONS 83-9-501 THROUGH 83-9-519, MISSISSIPPI CODE OF 1972, TO ENACT THE MISSISSIPPI PREAUTHORIZATION GOLD CARD ACT; TO PROVIDE DEFINITIONS; TO PROVIDE EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES; TO PROVIDE FOR THE DURATION OF PREAUTHORIZATION EXEMPTION; TO PROVIDE FOR THE DENIAL OR RECISSION OF PREAUTHORIZATION EXEMPTION; TO PROVIDE FOR INDEPENDENT REVIEW OF THE EXEMPTION DETERMINATION; TO PROVIDE FOR THE EFFECT OF APPEAL OR INDEPENDENT REVIEW DETERMINATION; TO PROVIDE ELIGIBILITY FOR PREAUTHORIZATION EXEMPTION FOLLOWING FINALIZED EXEMPTION RECISSION OR DENIAL; TO PROVIDE THE EFFECT OF PREAUTHORIZATION EXEMPTION; AND FOR RELATED PURPOSES.

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

SECTION 1. The following shall be codified as Section 83-9-501, Mississippi Code of 1972:

83-9-501. This act shall be known and may be cited as the "Mississippi Preauthorization Gold Card Act."

SECTION 2. The following shall be codified as Section 83-9-503, Mississippi Code of 1972:

83-9-503. As used in this act, the following terms shall have the following meanings, unless the context clearly indicates otherwise:

(a) (i) "Health benefit plan" means a plan, policy, contract, certificate, agreement, or other evidence of coverage for healthcare services offered or issued by a healthcare insurer in this state and such products as described in Section 83-9-1.

(ii) "Health benefit plan" includes nonfederal governmental plans as defined in 29 USC Section 1002(32), as it existed on January 1, 2019.

(iii) "Health benefit plan" does not include:

1. A disability income plan;

2. A credit insurance plan;

3. Insurance coverage issued as a supplement to liability insurance;

4. A medical payment under automobile or homeowners insurance plans;

5. A health benefit plan provided for State and School Employees or Workers Compensation;

6. A plan that provides only indemnity for hospital confinement;

7. An accident-only plan;

8. A specified disease plan; or

9. A long-term-care only plan;

(b) "Healthcare contract" means a contract entered into, materially amended, or renewed between a contracting entity and a healthcare provider for the delivery of healthcare services to enrollees;

(c) (i) "Healthcare insurer" means an entity that is subject to state insurance regulation and provides health insurance in this state.

(ii) "Healthcare insurer" includes:

1. An insurance company;

2. A health maintenance organization or managed care organization;

3. A hospital and medical service corporation;

4. A risk-based provider organization;

5. A sponsor of a nonfederal self-funded governmental plan;

6. A care coordination organization; and

7. A provider sponsored health plan;

(d) "Healthcare provider" means a person or entity that is licensed, certified, or otherwise authorized by the laws of this state to provide healthcare services;

(e) "Healthcare services" means services or goods provided for the purpose of or incidental to the purpose of preventing, diagnosing, treating, alleviating, relieving, curing, or healing human illness, disease, condition, disability, or injury;

(f) "Preauthorization" means a determination by a health benefit plan or healthcare insurer or person contracting with a health benefit plan or healthcare insurer that health care

services proposed to be provided to a patient are medically necessary and appropriate.

SECTION 3. The following shall be codified as Section 83-9-505, Mississippi Code of 1972:

83-9-505. This subchapter applies to a health benefit plan or healthcare insurer as defined in Section 2 of this act, including any health benefit plan or healthcare insurer under contract with the Division of Medicaid. The Division of Medicaid is not itself considered a health benefit plan or healthcare insurer. The provisions of this act only apply to a request for preauthorization of health care services made on or after January 1, 2023. A request for preauthorization of health care services made before January 1, 2023, is governed by the law as it existed immediately before the effective date of this act and that law is continued in effect for that purpose.

SECTION 4. The following shall be codified as Section 83-9-507, Mississippi Code of 1972:

83-9-507. (1) A health maintenance organization or an insurer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if, in the most recent six-month evaluation period, as described by subsection (2) of this section, the health maintenance organization or insurer has approved or would have approved not less than ninety percent (90%) of the preauthorization requests

submitted by the physician or provider for the particular health care service.

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

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

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

SECTION 5. The following shall be codified as Section 83-9-509, Mississippi Code of 1972:

83-9-509. (1) A physician's or provider's exemption from preauthorization requirements under applicable law remains in effect until:

(a) The thirtieth day after the date the health maintenance organization or insurer notifies the physician or provider of the health maintenance organization's or insurer's determination to rescind the exemption under Section 6 of this

act, if the physician provider does not appeal the health maintenance organization's or insurer's determination; or

(b) If the physician or provider appeals the determination, the fifth day after the date the independent review organization affirms the health maintenance organization's or insurer's determination to rescind the exemption.

(2) If a health maintenance organization or insurer does not finalize a recission determination as specified in subsection (1) of this section, then the physician or provider is considered to have met the criteria under Section 83-9-504 to continue to qualify for the exemption.

SECTION 6. The following shall be codified as Section 83-9-511, Mississippi Code of 1972:

83-9-511. (1) A health maintenance organization or insurer may rescind an exemption from preauthorization requirements under Section 83-9-504 only:

(a) During January or June of each year;

(b) If the health maintenance organization or insurer makes a determination, on the basis of a retrospective review of a random sample of not fewer than five (5) and no more than twenty (20) claims submitted by the physician or provider during the most recent evaluation period described by Section 83-9-504, that less than ninety percent (90%) of the claims for the particular health care service met the medical necessity criteria that would have been used by the health maintenance organization or insurer when

conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(c) If the health maintenance organization or insurer complies with other applicable requirements specified in this section, including:

(i) Notifying the physician or provider not less than twenty-five (25) days before the proposed rescission is to take effect; and

(ii) Providing with the notice under subsection (1) of this section:

1. The sample information used to make the determination under subsection (1)(b) of this section; and

2. A plain language explanation of how the physician or provider may appeal and seek an independent review of the determination.

(2) A determination made under subsection (1)(b) of this section must be made by an individual licensed to practice medicine in this state. For a determination made under subsection (1)(b) of this section with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

(3) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 83-9-504 only if:

(a) The physician or provider does not have the exemption at the time of the relevant evaluation period; and

(b) The health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from preauthorization requirements for the particular health care service under applicable law.

SECTION 7. The following shall be codified as Section 83-9-513, Mississippi Code of 1972:

83-9-513. (1) A physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption be conducted by an independent review organization. A health maintenance organization or insurer may not require a physician or provider to engage in an internal appeal process before requesting a review by an independent review organization under this section.

(2) A health maintenance organization or insurer shall pay:

(a) For any appeal or independent review of an adverse determination regarding a preauthorization exemption requested under this section; and

(b) A reasonable fee for any copies of medical records or other documents requested from a physician or provider during an exemption rescission review requested under this section.

(3) An independent review organization must complete an expedited review of an adverse determination regarding a preauthorization exemption not later than the thirtieth day after the date a physician or provider files the request for a review under this section.

(4) A physician or provider may request that the independent review organization consider another random sample of not less than five (5) and no more than twenty (20) claims submitted to the health maintenance organization or insurer by the physician or provider during the relevant evaluation period for the relevant health care service as part of its review. If the physician or provider makes a request under this subsection (4), the independent review organization shall base its determination on the medical necessity of claims reviewed by the health maintenance organization or insurer under Section 83-9-506 and reviewed under this subsection (4).

SECTION 8. The following shall be codified as Section 83-9-515, Mississippi Code of 1972:

83-9-515. (1) A health maintenance organization or insurer is bound by an appeal or independent review determination that does not affirm the determination made by the health maintenance organization or insurer to rescind a preauthorization exemption.

(2) A health maintenance organization or insurer may not retroactively deny a health care service on the basis of a rescission of an exemption, even if the health maintenance

organization's or insurer's determination to rescind the preauthorization exemption is affirmed by an independent review organization.

(3) If a determination of a preauthorization exemption made by the health maintenance organization or insurer is overturned on review by an independent review organization, the health maintenance organization or insurer:

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

(b) may only rescind the exemption after if the health maintenance organization or insurer complies with the provisions of this act.

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

83-9-517. After a final determination or review affirming the rescission or denial of an exemption for a specific health care service under Section 83-9-504 a physician or provider is eligible for consideration of an exemption for the same health care service after the six-month evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

SECTION 10. The following shall be codified as Section 83-9-519, Mississippi Code of 1972:

83-9-519. (1) A health maintenance organization or insurer may not deny or reduce payment to a physician or provider for a

health care service for which the physician or provider has qualified for an exemption from preauthorization requirements under Section 83-9-504 based on medical necessity or appropriateness of care unless the physician or provider:

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

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

(2) A health maintenance organization or an insurer may not conduct a retrospective review of a health care service subject to an exemption except:

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

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

(3) For a retrospective review described by subsection (2)(b) of this section, nothing in this act may be construed to modify or otherwise affect:

(a) The requirements under or application of applicable law, including any timeframes specified by that section; or

(b) Any other applicable law, except to prescribe the only circumstances under which:

(i) A retrospective utilization review may occur as specified by subsection (2)(b) of this section; or

(ii) Payment may be denied or reduced as specified by subsection (1) of this section.

(4) Not later than five (5) days after qualifying for an exemption from preauthorization requirements under Section 83-9-504, a health maintenance organization or insurer must provide to a physician or provider a notice that includes:

(a) A statement that the physician or provider qualifies for an exemption from preauthorization requirements under Section 83-9-504;

(b) A list of the health care services and health benefit plans to which the exemption applies; and

(c) A statement of the duration of the exemption.

(5) If a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for an exemption from preauthorization requirements under Section 83-9-504, the health maintenance organization or insurer must promptly provide a notice to the physician or provider that includes:

(a) The information described by subsection (4) of this section; and

(b) A notification of the health maintenance organization's or insurer's payment requirements.

(6) Nothing in this act may be construed to:

(a) Authorize a physician or provider to provide a health care service outside the scope of the provider's applicable license; or

(b) Require a health maintenance organization or insurer to pay for a health care service that is performed in violation of the laws of this state.

SECTION 11. This act shall take effect and be in force from and after July 1, 2022.