PROPOSED RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plans.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Preauthorization is to determine if the procedure or treatment is medically necessary. The claims administrator will determine what procedures or treatments are subject to preauthorization. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, or who are enrolled in the Medicare Advantage Plan are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person’s health condition or the cause of the condition may be rescinded.

1. A list of medical services for which preauthorization is required may be obtained at any time from the claims administrator.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

   A. Second-step therapy medications that skip the first-step medication trial;
   
   B. Specialty medications;
   
   C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;
   
   D. Medication refill requests that are before the time allowed for refill;
   
   E. Medications that exceed drug quantity and day supply limitations; and
   
   F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

   A. A benefit determination for non-urgent preauthorization requests will be made within thirty-six (36) hours, which will include one (1) business day of the receipt of the request. If the information necessary to make a benefit determination is not received, the claims administrator will notify the member and provider of any necessary extension. The provider will be given forty-five (45) calendar days from receipt of the extension notice to respond with additional information. Once the information is received or the forty-five (45) days have elapsed, a determination will be made within thirty-six (36) hours which will include one (1) business day.

   B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than one (1) business day of the receipt of all necessary information;

   (B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision;

   (C) Retrospective Review—Reviews to determine coverage after services have been provided to a member. The retrospective review is not limited to an evaluation of medical necessity, reimbursement
levels, accuracy and adequacy of documentation or coding, or settling of payment. The claim administrator shall have the authority to correct payment errors when identified under retrospective review;

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment; and

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.


PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.