L.D. 1383

Date: (Filing No. S-)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

131ST LEGISLATURE

FIRST SPECIAL SESSION

COMMITTEE AMENDMENT " " to S.P. 548, L.D. 1383, "An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services"

Amend the bill by striking out the title and substituting the following:

'An Act to Regulate Insurance Carrier Prior Authorization Requirements for Rehabilitative and Habilitative Services'

Amend the bill by striking out everything after the enacting clause and inserting the following:

'**Sec. 1. 24-A MRSA §4304, sub-§1,** as amended by PL 2007, c. 199, Pt. B, §13, is further amended to read:

1. Requirements for medical review or utilization review practices. A carrier ~~must~~ shall appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter. A carrier shall provide clear written policies and procedures to providers and enrollees on how to obtain a prior authorization.

Sec. 2. 24-A MRSA §4304-A is enacted to read:

§4304-A. Prior authorization for rehabilitative or habilitative services

1. Prior authorization for new episode of care prohibited for 12 visits. A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. For purposes of this subsection, "new episode of care" means treatment for a new condition or treatment for a recurring condition for which an enrollee has not been treated within the previous 90 days.

2. Intent. This section does not limit the right of a carrier to deny a claim when an appropriate prospective or retrospective review concludes that the health care services or treatment rendered were not medically necessary.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment, which is the majority report of the committee, replaces the bill and changes the title. The amendment retains the following provisions from the bill:

1. It requires a health insurance carrier to provide clear written policies and procedures to health care providers and enrollees on how to obtain a prior authorization; and

2. It prohibits a carrier from requiring prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care.

The amendment clarifies that the prior authorization provision in the bill does not limit the right of a carrier to deny a claim when appropriate prospective or retrospective review concludes that services or treatment rendered were not medically necessary.

FISCAL NOTE REQUIRED

(See attached)