131st MAINE LEGISLATURE

FIRST REGULAR SESSION-2023

Legislative Document	**No. 1383**
S.P. 548	In Senate, March 28, 2023

An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator BRENNER of Cumberland.
Cosponsored by Representative MATHIESON of Kittery and
Senators: BENNETT of Oxford, HICKMAN of Kennebec, Representatives: ARFORD of Brunswick, COPELAND of Saco, GEIGER of Rockland, GRAHAM of North Yarmouth, MORRIS of Turner, MURPHY of Scarborough.

Be it enacted by the People of the State of Maine as follows:

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 insureds on how to obtain a prior authorization.

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

§4304-A. Prior authorization for physical therapy, occupational therapy, chiropractic services and physical medicine or rehabilitation

This section governs prior authorization for physical therapy, occupational therapy and physical medicine or rehabilitation.

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, 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 or recurring condition for which an insured has not been treated by the provider within the previous 90 days. After the 12 visits of each new episode of care, a carrier may not require prior authorization more frequently than every 6 visits or every 30 days, whichever time period is longer.

2. Prior authorization for chronic pain prohibited for 90 days. A carrier may not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first 90 days following diagnosis in order to provide the necessary nonpharmacologic management of the pain. After the first 90 days following a chronic pain diagnosis, a carrier may not require prior authorization more frequently than every 6 visits or every 30 days, whichever time period is longer. For purposes of this subsection, "chronic pain" means pain that persists or recurs for more than 3 months.

3. Response time; additional information. A carrier shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within 24 hours. If a carrier requires more information to make a decision on the prior authorization request, the carrier shall notify the patient and the provider within 24 hours of the initial request with the information that is needed to complete the prior authorization request, including but not limited to the specific tests and measures needed from the patient and provider. A carrier shall make a decision on the prior authorization request within 24 hours of receiving the requested information.

4. Approval of prior authorization. This subsection governs circumstances in which a prior authorization for covered services under this section is deemed to be approved by a carrier. A prior authorization is deemed to be approved if a carrier:

A. Fails to timely answer a prior authorization request in accordance with subsection 3, including due to a failure of the carrier's prior authorization platform or process; or

B. Informs a provider that prior authorization is not required orally, via an online platform or program, through the patient's health plan documents or by any other means.

5. Retroactive authorization. A carrier shall provide a procedure for providers and insureds to obtain retroactive authorization for services under this section that are medically necessary covered benefits. A carrier may not deny coverage for medically necessary services under this section only for failure to obtain a prior authorization, if a medical necessity determination can be made after the services have been provided and the services would have been covered benefits if prior authorization had been obtained.

6. Appeal. A carrier's failure to approve a prior authorization for all services or visits in a plan of care under this section is subject to the same appeal rights as a denial under the bureau's rule regarding health plan accountability and the provider's network agreement with the carrier, if any.

7. Intent. Nothing in this section is intended to prohibit a carrier from performing a retrospective medical necessity review.

SUMMARY

This bill enacts provisions of law relating to prior authorization for physical therapy, occupational therapy, chiropractic services and physical medicine and rehabilitation services.