

STATE OF OKLAHOMA

1st Session of the 43rd Legislature (1991)

HOUSE BILL NO. 1384

BY: PILGRIM

AS INTRODUCED

AN ACT RELATING TO INSURANCE; CREATING THE HEALTH SERVICES UTILIZATION REVIEW ACT; PROVIDING SHORT TITLE; DECLARING PURPOSE; PROVIDING LEGISLATIVE INTENT; DEFINING TERMS; REQUIRING THE CERTIFICATION OF PRIVATE REVIEW AGENTS; ESTABLISHING REQUIREMENTS FOR CERTIFICATION; PROVIDING FOR APPLICATIONS, FEES, AND SUBMISSIONS; PROVIDING FOR CERTIFICATE EXPIRATION, RENEWAL, DENIAL, AND REVOCATION AND ADMINISTRATIVE AND JUDICIAL PROCEEDINGS RELATING THERETO; PROVIDING FOR LISTINGS OF CERTIFICATE HOLDERS; PROVIDING FOR REPORTS; PROVIDING FOR RULES AND REGULATIONS; PROVIDING FOR EXEMPTIONS FROM THE ACT; PROVIDING FOR CODIFICATION; AND PROVIDING AN EFFECTIVE DATE.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4431 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 14 of this act shall constitute a part of the Oklahoma Insurance Code and shall be known and may be cited as the "Health Services Utilization Review Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4432 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The purpose of the Health Services Utilization Review Act is to promote the delivery of quality health care in this state. Furthermore, it is to foster the delivery of such care in a cost-effective manner through greater coordination between health care providers, claim administrators, payors, employers, patients, and private review agents; to improve communication and knowledge of health care benefits among all parties; to protect patients, claim administrators, payors, private review agents, employers, and health care providers by ensuring that utilization review activities are based upon accepted standards of treatment and patient care; to ensure that such treatment is accessible and done in a timely and effective manner; and to ensure that private review agents maintain confidentiality of information obtained in the course of utilization review.

B. It is the intent of the Legislature to protect residents of this state by imposing minimum standards on private review agents who engage in utilization review with respect to health care services provided in this state. The standards shall include regulations concerning certification of private review agents, disclosure of utilization review standards and appeal procedures, minimum qualifications for utilization review personnel, minimum standards governing accessibility of utilization review and such other standards, requirements, and rules or regulations promulgated by the Insurance Commissioner which are consistent with the purposes of the Health Services Utilization Review Act. It is neither the policy nor the intent of the Legislature to regulate the terms of

self-insured employee welfare benefit plans as defined in Section 31(I) of the Employee Retirement Income Security Act of 1974, as amended, and therefore any regulations promulgated and adopted pursuant to the Health Services Utilization Review Act shall relate only to persons subject to said act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4433 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Health Services Utilization Review Act:

1. "Certificate" means a certificate of registration granted by the Insurance Commissioner to a private review agent;

2. "Claim administrator" means any entity that reviews and determines whether to pay claims to enrollees of health care providers on behalf of the health benefit plan. Claim administrators may be payors or their designated review organizations, self-insured employers, management firms, third-party administrators, or other private contractors;

3. "Commissioner" means the Commissioner of Insurance;

4. "Enrollee" means the individual who has elected to contract for or participate in a health benefit plan for himself or himself and his eligible dependents;

5. "Health benefit plan" means a plan of benefits that defines the coverage provisions for health care for enrollees offered or provided by any organization, public or private;

6. "Health care provider" means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing health care services, including, but not limited to, a doctor of medicine, doctor of osteopathy, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker;

7. "Payor" means any insurer, preferred provider organization, health maintenance organization, self-insurance plan, or other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health care benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract of accident and health insurance;

8. "Private review agent" means any person or entity which performs utilization review for:

- a. an employer with employees who are treated by a health care provider in this state,
- b. a payor, or
- c. a claim administrator;

9. "Reasonable target review period" means the assignment of a proposed number of days for review for the proposed health care services based upon reasonable length of stay standards including, but not limited to, national or regional length of stay standards or available specific length of stay standards or data for this state;

10. "Utilization review" means a system for reviewing the appropriate and efficient allocation or charges of hospital, outpatient, medical, or other health care services given or proposed to be given to a patient or group of patients for the purpose of advising the claim administrator who determines whether such services or the charges therefor should be covered, provided, or reimbursed by a payor according to the benefits plan. Utilization review shall not include the review or adjustment of claims or the payment of benefits arising under liability, workers' compensation, or malpractice insurance policies; and

11. "Utilization review plan" means a reasonable description of the standards, criteria, policies, procedures, target review periods, and reconsideration and appeal mechanisms governing utilization review activities performed by a private review agent.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4434 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A private review agent shall not conduct utilization review of health care provided in this state unless the Commissioner has granted the private review agent a certificate pursuant to the Health Services Utilization Review Act. No individual conducting utilization review shall be required to be certified if such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to the Health Services Utilization Review Act.

B. The Commissioner shall issue a certificate to an applicant that has met all the requirements of the Health Services Utilization Review Act and all applicable regulations of the Commissioner.

C. A certificate issued pursuant to the Health Services Utilization Review Act shall not be transferable without the prior approval of the Commissioner.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4435 of Title 36, unless there is created a duplication in numbering, reads as follows:

As a condition of certification or renewal thereof, a private review agent shall comply with the following requirements:

1. The medical protocols, including reconsideration and appeal process as well as other relevant medical issues used in the private review program, shall be made available upon request of health care providers and shall be established pursuant to input from:

- a. health care providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency; or

- b. persons who are licensed in the appropriate health care provider's specialty recognized by a licensure agency of such a health care provider;

2. All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating health care provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

3. In the absence of any contractual agreement between the health care provider and the payor, the responsibility for obtaining precertification as well as concurrent review required by the payor shall be the responsibility of the enrollee;

4. In cases in which a private review agent is responsible for utilization review for a payor or claim administrator, the utilization review agent shall respond promptly and efficiently to all requests including concurrent review in a timely method and a method for an expedited authorization process shall be available in the interest of efficient patient care;

5. In any instances in which the utilization review agent is questioning the medical necessity or appropriateness of care, no adverse determination shall be made by the utilization review agent until the review agent discusses the patient's care and plan of treatment with the patient's attending provider and, if requested by the attending provider, a health care provider, designated by the attending provider, and trained in a speciality that has a bearing on the patient's treatment. In the event of an adverse determination, notice to the provider and patient shall specify the reasons for the review determination;

6. A private review agent shall assign a reasonable target review period for each admission promptly upon notification by the health care provider. Once a target length of stay has been agreed upon with the health care provider, the utilization review agent shall not attempt to contact the health care provider or patient for

further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or health care provider. The provider or the health care facility shall be responsible for alerting the utilization review agent in the event of a change in proposed treatment. At the end of the target period, the private review agent shall review the care for a continued stay;

7. A private review agent shall not enter into any incentive payment provision contained in a contract or agreement with a payor which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings; and

8. Any health care provider may designate one or more individuals to be contacted by the private review agent for information or data. In the event of any such designation, the private review agent shall not contact other employees or personnel of the health care provider except with prior consent by the health care provider. An alternate designee shall be available during normal business hours if the designated individual is absent or unavailable.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4436 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An applicant for a certificate shall submit an application on a form prescribed by the Commissioner and shall pay an application fee of Twenty-five Dollars (\$25.00) and a certificate fee of Four Hundred Dollars (\$400.00). The application shall be signed and verified by the applicant.

B. In conjunction with the application, the private review agent shall submit any information that the Commissioner requires, including but not limited to:

1. A utilization review plan;

2. The type and qualifications of the personnel either employed or under contract to perform the utilization review; and

3. A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan.

The information provided shall demonstrate to the satisfaction of the Commissioner that the private review agent shall comply with the requirements of the Health Services Utilization Review Act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4437 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A certificate shall expire on the second anniversary of its effective date, unless the certificate is renewed for a two-year term as provided in this section.

B. Before the certificate expires but no sooner than ninety (90) days prior to expiration, a certificate may be renewed for an additional two-year term if the applicant:

1. Otherwise is entitled to the certificate;

2. Pays to the Commissioner the renewal fee in the amount of Four Hundred Dollars (\$400.00);

3. Submits to the Commissioner:

a. A renewal application on the form that the Commissioner requires, and

b. Satisfactory evidence of compliance with any requirements established by the Commissioner for certificate renewal;

4. Establishes and maintains a complaint system which has been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints initiated by enrollees or health care providers concerning utilization review;

5. Maintains records of written complaints for five (5) years from the time the complaints are filed and submits to the

Commissioner a summary report at such times and in such format as the Commissioner may require; and

6. Permits the Commissioner to examine the records of complaints at any time.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4438 of Title 36, unless there is created a duplication in numbering, reads as follows:

Private review agents shall be subject to the jurisdiction of the Commissioner in all matters regulated by the Health Services Utilization Review Act and the Commissioner shall have such powers and authority with regard to private review agents as provided in the Oklahoma Insurance Code with regard to insurers.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4439 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall periodically, not less than once a year, provide a list of private review agents issued certificates and the renewal date for those certificates to all hospitals and to any other individual or organization requesting the list.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4440 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall establish such reporting requirements upon private review agents as are necessary to determine if the utilization review programs are in compliance with the provisions of the Health Services Utilization Review Act and applicable rules and regulations.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4441 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall promulgate and adopt rules and regulations to implement the provisions of the Health Services Utilization Review Act.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4442 of Title 36, unless there is created a duplication in numbering, reads as follows:

No certificate shall be required for utilization review by any pharmacist or pharmacy licensed in this state, while engaged in the practice of pharmacy, including but not limited to review of the dispensing of drugs, participation in drug utilization review, and monitoring patient drug therapy.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4443 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Health Services Utilization Review Act shall not apply to:

1. Any contract with the federal government for utilization and review of patients eligible for hospital services pursuant to Titles XVIII or XIX of the Social Security Act.

2. Any private review agent if such private review agent is working under contract, or an extension or renewal thereof, with a licensed insurer operating pursuant to an agreement, providing administrative services to a health care benefit plan negotiated through collective bargaining, as that term is defined in the federal National Labor Relations Act, as amended, if the original agreement was executed and in effect prior to January 1, 1992.

3. Audits of the medical record for the purposes of verifying that health care services were ordered and delivered.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4444 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall issue an annual report to the Governor, the Speaker of the House of Representatives, and the President Pro

Tempore of the Senate, concerning the conduct of utilization review in this state. The report shall include a description of utilization review programs and the services provided by the programs, an analysis of complaints filed against private review agents by patients or providers, and an evaluation of the impact of utilization review programs on patient access to care.

SECTION 15. This act shall become effective January 1, 1992.

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