

ENROLLED SENATE
BILL NO. 92

By: Hobson of the Senate

and

Crocker of the House

An Act relating to insurance; amending 36 O.S. 1991, Section 1254, which relates to acts prohibited by the Claims Resolution Act; modifying requirements for determination of medical necessity; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 1254, is amended to read as follows:

Section 1254. 1. No insurer shall fail to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

2. No agent shall conceal from first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

3. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

4. No insurer, except where there is a time limit specified in the policy, shall make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices an insurer's rights.

5. No insurer shall request a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases an insurer or its insured from its total liability.

7. No insurer transacting health insurance in this state, or administrator, as defined in Section 1442 of this title, shall deny payment to a claimant on the grounds that services, procedures or supplies provided by a treating physician or a hospital were not medically necessary unless said health insurer or administrator first obtains ~~a report prepared and signed by~~ an opinion from a licensed health care provider, and preceded by a medical examination or claim review, stating to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. ~~The report~~ Upon written request of a claimant, treating

physician or hospital, such opinion shall be set forth in a written report, prepared and signed by the reviewing health care provider. The report shall detail which specific services, procedures and or supplies were not medically necessary, in the opinion of the reviewing health care provider, and an explanation of that conclusion. A copy of each report of a reviewing health care provider shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, or the treating physician or hospital requesting same within fifteen (15) days after receipt of a such written request. As used in this subsection, "physician" means a person holding a valid license to practice medicine and surgery, osteopathy, podiatry, chiropractic or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes.

8. No insurer transacting health insurance in this state, or administrator, as defined in Section 1442 of this title, shall compensate a reviewing health care provider on the basis of a percentage of the amount by which a claim is reduced for payment.

9. All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check or draft, payable on demand.

SECTION 2. This act shall become effective September 1, 1993.

Passed the Senate the 24th day of February, 1993.

President of the Senate

Passed the House of Representatives the 23rd day of March, 1993.

Speaker of the House of Representatives