STATE OF OKLAHOMA

2nd Session of the 46th Legislature (1998)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2280 By: Stanley

COMMITTEE SUBSTITUTE

An Act relating to health care; prohibiting a managed care plan from requiring certain conditions for coverage of emergency services and care; requiring determination of an emergency medical condition by a physician or medical personnel; providing for compensation for certain services by a provider; requiring the hospital to notify the primary care physician or managed care plan; providing for documentation of notification attempts; prohibiting managed care plan from denying payments for failure to notify; providing for discussion and participation in treatment with certain physicians; allowing for the transfer of patients to certain hospitals; allowing hospitals to collect certain insurance or financial information from patient; allowing for emergency room use copayment charge; providing for reimbursement for services to certain providers; defining certain terms; 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 2528 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. In providing for emergency services and care as a covered service, a managed care plan shall not:

1. Require prior authorization for the receipt of prehospital transport or treatment or for emergency services and care;

2. Indicate that emergencies are covered only if care is secured within a certain period of time;

3. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or

4. Deny payment based on the failure of the enrollee or the hospital to notify the managed care plan or provider in advance or within a certain period of time after the care is given.

B. When an enrollee of a managed care plan is present at a hospital seeking emergency services and care, the determination as to whether an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The physician or the appropriate personnel shall indicate in the patient's chart the results of the screening, examination, and evaluation. The managed care plan shall compensate the provider for screening, evaluating, and examining of the patient that are reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The managed care plan shall compensate the provider for emergency services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the managed care plan contract.

C. If a determination has been made that an emergency medical condition exists and the enrollee has notified the hospital, or the hospital emergency personnel otherwise has knowledge that the patient is an enrollee of the managed care plan, the hospital shall make a reasonable attempt to notify the primary care physician of the enrollee, if known, or the managed care plan, if the managed care plan had previously requested in writing that the notification be made directly to the managed care plan. If the primary care physician is not known, or has not been contacted, the hospital shall:

1. Notify the managed care plan as soon as possible prior to discharge of the enrollee from the emergency care area; or

2. Notify the managed care plan within twenty-four (24) hours or on the next business day after admission of the enrollee as an inpatient to the hospital.

If notification required by this subsection is not accomplished, the hospital shall document its attempts to notify the managed care plan or the circumstance that precluded attempts to notify the managed care plan. A managed care plan shall not deny payment for emergency services and care based on the failure of a hospital to comply with the notification requirements of this subsection.

D. If the primary care physician for the enrollee responds to the notification, the hospital physician and the primary care physician may discuss the appropriate care and treatment of the enrollee. The managed care plan may have a member of the hospital staff with whom it has a contract participate in the treatment of the enrollee within the scope of the hospital staff privileges of that physician. The enrollee may be transferred, in accordance with state and federal law, to a hospital that has a contract with the managed care plan and has the service capability to treat the emergency medical condition of the enrollee. A hospital may request and collect insurance or financial information from a patient in accordance with federal law, which is necessary to determine if the patient is an enrollee of a managed care plan, if doing so would not delay emergency services and care.

E. Nothing in this section is intended to prohibit or limit application of a nominal copayment for the use of an emergency room for services other than emergency services and care.

F. Reimbursement for services provided to an enrollee of a managed care plan under this section by a provider who does not have a contract with the managed care plan shall be the lesser of:

1. The charges of the provider;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within sixty (60) days after submittal of the claim; or

4. The Medicare rate.

G. As used in this section:

1. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which

may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in the following:

a. serious jeopardy to the health of a patient, including a pregnant woman or a fetus,

b. serious impairment of bodily functions, or

c. serious dysfunction of any bodily organ or part.

With respect to a pregnant woman, an emergency medical condition exists when there is inadequate time to effect safe transfer to another hospital prior to delivery, when a transfer to another hospital may pose a threat to the health and safety of the patient or fetus, or when there is evidence of the onset and persistence of uterine contractions or rupture of the membranes;

2. "Emergency services and care" means medical screening, examination, and evaluation by a physician or other appropriate medical personnel to determine whether an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition; and

3. "Managed care plan" means a managed care plan as defined in Section 2525.3 of Title 63 of the Oklahoma Statutes and a participating provider in the Oklahoma Medicaid Healthcare Options System as defined in Section 1010.2 of Title 56 of the Oklahoma Statutes.

SECTION 2. This act shall become effective November 1, 1998.

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