STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 1826 By: Boyd and Roach of the House

and

Fisher of the Senate

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to managed health care; creating the Oklahoma Managed Care External Review Act; defining terms; providing for right for external review of decisions made by certain entity subject to certain conditions; specifying conditions; requiring certain entities to establish internal reviews; providing for certain exemptions; expanding the duties of the State Board of Health, the State Department of Health and the Insurance Commissioner; directing the promulgation of certain rules for certain internal reviews; establishing procedures and requirements for certain external reviews; requiring payment of certain fees; providing for refunds; providing for payment of costs; providing for certain rebuttable presumptions; limiting certain appeals; requiring the providing of certain information; requiring certain notice and procedures; providing for construction of act; providing for release of liability of certain entities; providing for informed consent; prohibiting certain removals of physician for certain reasons; providing for external reviews; specifying certain procedures; requiring certain selections and notices; providing for objections; setting certain time periods; requiring certain documents; providing for preliminary reviews; setting conditions for acceptance and denial of certain reviews; requiring for notification and contents; requiring submission of certain documents; providing exceptions; requiring confidentiality; providing for emergencies; providing for certain determinations by certain external review organizations; providing for conditions, evidence, standards and basis for review; requiring certification of certain external review organizations; providing for promulgation of certain rules and standards; providing for content; providing for certification of certain entities; authorizing issuance, renewal, nonrenewal, revocation, denial and suspension of certifications; prohibiting certification of certain entities; making certain requirements for expert reviewers; prohibiting and providing for certain conflict of interest; providing for codification; and providing effective dates.

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 2528.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Managed Care External Review Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Managed Care External Review Act:

1. "Designee of an insured person" means an individual designated through expressed written consent by an insured person to represent the interests of the insured person, including, but not limited to, the insured person's physician or where applicable such person's primary care physician;

2. "External review" means a review of a decision by a health benefit plan to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit by an independent review organization upon the request of an insured person or the designee of an insured person, and the organization's subsequent decision to uphold or reverse the denial of such coverage or reimbursement made by the health benefit plan;

3. "Health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization, a preferred provider plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA), or a self-insured plan;

4. "Independent review organization" means an entity certified by the State Department of Health to conduct external reviews;

5. “Insured person” means an individual who receives medical care and treatment through a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of such person;

6. “Internal review” means procedures established by a health benefit plan, pursuant to the provisions of Section 4 of this act, for an internal reevaluation of an initial decision to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit, and the subsequent decision by the health benefit plan to grant or deny such coverage or reimbursement; and

7. “Physician” means and includes each of the classes of persons listed by Section 725.2 of Title 59 of the Oklahoma Statutes.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

An insured person shall have the right to an external review by an independent review organization of a decision under a health benefit plan to deny coverage of or reimbursement for a medical treatment or service to the insured person that is otherwise a covered benefit when:

1. All applicable internal appeals procedures established by the health benefit plan have been exhausted;

2. The denial is based on a determination by the health benefit plan that the service or treatment is not medically necessary, medically appropriate, or medically effective;

3. The usual, customary and reasonable charge or allowable charge, as shown in the health benefit plan’s fee schedule, of the service or treatment for which coverage or reimbursement was denied

by the health benefit plan exceeds One Thousand Dollars ($1,000.00); and

4. The insured person or the designee of the insured person agrees to the terms and conditions of external review as provided in Section 5 of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Except as specifically provided by this section, every health benefit plan that is offered, issued or renewed after February 1, 2000, shall provide for an external review process by an independent review organization in accordance with the provisions of the Oklahoma Managed Care External Review Act. The following shall not be subject to the provisions of the Oklahoma Managed Care External Review Act:

1. Health benefit plans that do not use a primary care physician-based prior authorization system and that have written procedures that permit external review;

2. Health benefit plans and health care provided pursuant to Titles XVIII, XIX or XXI of the federal Social Security Act; and

3. Workers' compensation benefits or coverage subject to the provisions of Title 85 of the Oklahoma Statutes.

B. Every health benefit plan subject to the provisions of the Oklahoma Managed Care External Review Act shall establish internal appeals procedures in accordance with rules promulgated by the state regulatory entity of the health benefit plan. The State Board of Health and the Insurance Commissioner shall respectively promulgate rules for internal review procedures for the health benefit plans subject to licensure or regulation by the State Department of Health or the Insurance Department as applicable. The rules shall include but not be limited to provisions for expedited internal review procedures in emergency situations.

C. Upon the request of an insured person or the representative of an insured person, every health benefit plan shall provide the requester with clear information about the terms, conditions and procedures of the internal review process and the external review process.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. 1. An insured person or the designee of an insured person shall be required to pay Fifty Dollars ($50.00) to the health benefit plan toward the cost of an external review.

a. Such payment shall be due at the time the preliminary screening is completed and the insured person or the designee of the insured person is notified of a decision by the independent review organization to accept the appeal, pursuant to procedures specified in the Oklahoma Managed Care External Review Act, for a full external review.

b. At the completion of the external review, if the insured person prevails, the payment shall be refunded by the health benefit plan.

2. The health benefit plan shall be responsible for the remaining costs related to the external review process.

B. A determination in favor of the health benefit plan shall create a rebuttable presumption in any subsequent action at law that the plan’s coverage determination was appropriate.

C. The number of appeals for an external review by an insured person or a designee of the insured person shall be limited to one appeal per authorization decision.

D. The health benefit plan may, at its discretion, determine that additional information provided by the insured person or the designee or physician of the insured person justifies a

reconsideration of the decision to deny coverage or reimbursement. Upon notice to the insured person or the designee of the insured person and the independent review organization, a subsequent decision by the health benefit plan to grant coverage or reimbursement based upon such reconsideration shall terminate the external review.

E. Nothing in the Oklahoma Managed Care External Review Act shall be construed to:

1. Create any new private right or cause of action for or on behalf of any insured person; or

2. Render the health benefit plan liable for injuries or damages arising from any act or omission of the independent review organization.

F. Independent review organizations and expert reviewers assigned by an independent review organization to conduct an external review shall not be liable for injuries or damages arising from decisions made pursuant to the Oklahoma Managed Care External Review Act. This provision shall not apply to any act or omission by independent review organizations or expert reviewers that is made in bad faith or that involves gross negligence.

G. After an appeal has been accepted for external review by an independent review organization, an informed consent form, signed by the insured person or the designee of the insured person acknowledging receipt of a copy of the terms and conditions of the external review process as provided by this section and acknowledging understanding of and consent to such terms and conditions, shall be required prior to initiating a full external review.

H. A health benefit plan shall not remove a physician from its plan, refuse to renew a physician with the plan, or otherwise discipline a physician for advocating on behalf of an insured person in either an internal review or external review.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. An appeal of a decision by a health benefit plan to deny coverage or reimbursement for a service or treatment, except as provided in Section 7 of this act, and a request for an external review shall be initiated in writing by the insured person or the designee of the insured person. The request shall be delivered to the health benefit plan within thirty (30) days after receipt of written notification of the denial from the health benefit plan following completion of the internal review process.

B. 1. Upon receipt of the request for an external review, the health benefit plan shall immediately select and notify an independent review organization from a list of independent review organizations certified by the State Department of Health;

2. The Department shall notify the insured person or the designee of the insured person of the name and location of the independent review organization selected;

3. The insured person or the designee of the insured person may object to the selection for cause and shall make such objection known to the Department within three (3) days of the date of notification of the selection of the independent review organizations; and

4. The Department may, after reviewing the objection, allow the insured person or the designee of the insured person to select a different independent review organization from the list.

C. Within five (5) business days of notification of the final selection of an independent review organization, the insured person or the designee of the insured person shall provide the independent review organization with the following documents:

1. A written request for an external review of the decision by the health benefit plan to deny coverage or reimbursement and a statement of the reasons for the request for an external review;

2. A copy of the final decision to deny coverage or reimbursement made by the health benefit plan; and

3. A fully executed release authorizing the independent review organization to obtain necessary medical records from the health benefit plan and any relevant health care providers.

D. Upon receipt of a written request for an external review and other documentation required in subsection C of this section, the independent review organization shall conduct a preliminary review of the appeal and shall accept it for a full review when the independent review organization determines that:

1. The individual on whose behalf the appeal is made is or was an insured person;

2. The service or treatment for which coverage is desired or reimbursement is asked is a covered service or treatment, or a service or treatment provided by contract to the insured person;

3. The insured person or the designee of the insured person has exhausted the internal review procedures of the health benefit plan; and

4. The insured person or the designee of the insured person has notified the health benefit plan of an appeal of the decision and the request for an external review.

E. Upon the completion of the preliminary review, the independent review organization shall immediately submit written notification of its decision to accept or deny the appeal for full external review to the insured person or the designee of the insured person, the health benefit plan and, if possible, the physician of the insured person. If an appeal is denied for full external review, a statement of the reasons for such denial shall be included with the notification.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Upon receipt of notification of acceptance of an appeal for full external review from an independent review organization, the health benefit plan shall provide the independent review organization with the following documents within five (5) business days after receipt of the notification of acceptance of an appeal for full external review:

1. Any information that was submitted to the health benefit plan by the insured person or the designee or physician of the insured person in support of the request for coverage or reimbursement pursuant to the internal review process; and

2. A copy of the contract provisions upon which the denial of coverage or reimbursement was based, any statement by the health benefit plan explaining the reasons for the decision of the health benefit plan not to provide coverage or to deny reimbursement, and any other relevant documents used by the health benefit plan in making its decision.

B. Upon the request of the insured person or the designee of the insured person, the health benefit plan shall provide the information required by subsection A of this section to the insured person or the designee or physician of the insured person; provided, however, the health benefit plan shall not be required to provide any legally privileged information.

C. The independent review organization shall notify the insured person or the designee of the insured person of any additional information it requires within five (5) business days after receipt of the information submitted by the health benefit plan. The insured person or the designee of the insured person shall submit the additional information, or an explanation as to why the

additional information cannot be submitted, within five (5) business days of receipt of the request for additional information.

D. The independent review organization shall maintain the confidentiality of medical records submitted to it in accordance with state and federal law, and shall maintain the confidentiality of proprietary information submitted by the health benefit plan.

E. The independent review organization shall issue a written decision on the appeal, stating the reasons why the desired service or treatment or reimbursement for service or treatment should or should not be made by the health benefit plan. Such decision shall be sent or transmitted to the insured person or designee of the insured person, the physician of the insured person, and the health benefit plan that is the subject of its decision within thirty (30) days after acceptance of the appeal for external review and receipt of the documentation required by this section.

F. When the physician of the insured person certifies in writing that an emergency exists and that as such, the time frames established by this section would jeopardize the life or health of the insured person, the decision shall be rendered as rapidly as warranted by the condition of the insured person, but in no event shall such rendering exceed seventy-two (72) hours.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The decision of an independent review organization as to the resolution of an appeal shall be based upon a review of the written record before it. In reaching its decision, the independent review organization shall apply any applicable health benefit plan policy or contract provisions, taking into consideration all pertinent medical records, consulting physician reports, medical and scientific evidence, and other documentation submitted by the parties.

B. Medical and scientific evidence includes, but is not limited to, the following sources:

1. Peer-reviewed scientific studies published by medical journals that meet nationally recognized requirements for scientific manuscripts in that most of the published articles are submitted for review by experts who are not part of the editorial staff;

2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index medicus, excerpta medicus (EMBASE), medline, and Medlars data base of health services technology assessment research (HSTAR);

3. The following standard reference compendia:

a. the American Hospital Formulary Service-Drug Information,

b. the American Medical Association Drug Evaluation,

c. the American Dental Association Accepted Dental Therapeutics, and

d. the United States Pharmacopoeia-Drug Information; and

4. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including, but not limited to, the Federal Agency for Health Care Policy and Research, National Institutes for Health, the National Academy of Sciences, the Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.9 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules for the certification of independent review organizations. The rules promulgated by the Board shall:

1. Establish minimum standards that:

a. include procedures for accomplishing informed consent for the external review process,

b. ensure the independence and objectivity of the review organization and the review process,

c. ensure the independence and objectivity of health care professionals providing analyses, recommendations, and other requested information,

d. ensure the identity of the physician as defined in Title 59 of the Oklahoma Statutes cannot be a factor in the decision by the independent review organization,

e. provide for the confidentiality of medical records and other confidential information submitted by the physician, insured person or designee of an insured person,

f. provide for expedited appeals in emergency situations pursuant to Section 7 of this act, and

g. ensure fair business practices by independent review organizations.

B. The State Department of Health shall have the power and duty to issue, renew, not to renew, revoke, deny and suspend certifications of independent review organizations and shall enforce the rules promulgated by the Board.

C. The following organizations shall not be eligible for certification as an independent review organization:

1. Professional trade associations of health care providers or their subsidiaries or affiliates; and

2. Health plans or health plan associations or their subsidiaries or affiliates.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A person assigned by an independent review organization as an expert reviewer shall be a physician and shall:

1. Have expertise in the specific health condition of the insured person whose appeal is under review and have knowledge regarding the recommended service or treatment through actual clinical experience;

2. Hold a nonrestricted license to practice medicine in a state of the United States;

3. Be currently certified by an American medical specialty board recognized by the American Osteopathic Association and the American Board of Medical Specialties in the areas appropriate to the subject of review; and

4. Have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity.

B. Neither the expert reviewer nor the independent review organization shall have any material, professional, familial or financial conflict of interest with:

1. The health benefit plan;

2. Any officer, director, or management employee of the health benefit plan;

3. The physician, the physician’s medical group, or the independent practice association proposing the service or treatment;

4. The institution at which the service or treatment would be provided;

5. The development or manufacture of the principal drug, device, procedure or other therapy proposed for the insured person whose appeal is under review; or

6. The insured person or designee of the insured person who requested the external review.

C. A potential expert reviewer shall disclose any information regarding a potential conflict of interest to all parties to the review.

SECTION 11. Section 9 of this act shall become effective September 1, 1999.

SECTION 12. Sections 1 through 8 and Section 10 of this act shall become effective February 1, 2000.

47-1-6970 KSM 6/11/15