

STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

COMMITTEE SUBSTITUTE  
FOR  
HOUSE BILL NO. 2647

By: Morgan

COMMITTEE SUBSTITUTE

( Health care - internal review procedure - amending  
Section 2, Chapter 289, O.S.L. 1997, as amended by  
Section 5, Chapter 361, O.S.L. 1999 (63 O.S. Supp.  
1999, Section 2525.3) - Oklahoma Managed Care Act  
- amending Sections 2 and 4, Chapter 160, O.S.L.  
1999 (63 O.S. Supp. 1999, Sections 2528.2 and  
2528.4) - Oklahoma Managed Care External Review  
Act - codification -

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 6052.1 of Title 36, unless there  
is created a duplication in numbering, reads as follows:

A. Every health benefit plan shall establish an internal review  
procedure by which an insured person may appeal an adverse decision  
made by the health benefit plan.

B. The Insurance Commissioner shall promulgate rules  
establishing a standardized internal review procedure. The rules  
promulgated by the Commissioner shall establish minimum standards  
that:

1. Establish a procedure by which a health benefit plan  
maintains a record of internal reviews;

2. Provides that the internal review procedure be set forth in  
writing and made available to all insured persons;

3. Standardizes the number of steps involved in the review  
process;

4. Standardizes the time frames for the review process; and
5. Provides provisions for an expedited internal review

process.

C. As used in this section:

1. "Adverse decision" means a determination by a health benefit plan or a utilization review organization designated by the plan that an admission, continued stay, or other health care service has been reviewed and based upon the information provided, does not meet the requirements established by the plan for medical necessity, appropriateness, health care setting, level of care, level of effectiveness, and therefore the requested service is denied, reduced, or terminated; and

2. "Health benefit plan" means those entities subject to the Oklahoma Managed Care External Review Act.

SECTION 2. AMENDATORY Section 2, Chapter 289, O.S.L. 1997, as amended by Section 5, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2525.3), is amended to read as follows:

Section 2525.3 For purposes of the Oklahoma Managed Care Act:

1. "Emergency" means a patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

- a. jeopardy to the patient's health,
- b. impairment to bodily functions, or
- c. dysfunction of any bodily organ or part.

2. "Emergency care" means emergency department screening and care to achieve stabilization as needed for conditions that reasonably appear to constitute a life- or limb-threatening emergency based on the presenting symptoms of the patient;

~~2.~~ 3. "Managed care contractor" means a person that:

- a. establishes, operates or maintains a network of participating providers,
- b. conducts or arranges for utilization review activities, and
- c. contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan;

~~3.~~ 4. "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor;

~~4.~~ 5. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in the plan through:

- a. arrangements with selected providers to furnish health care services,
- b. standards for the selection of participating providers,
- c. organizational arrangements for ongoing quality assurance, utilization review, and dispute resolution, and
- d. financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

provided, however, the term "managed care plan" shall not include a certified workplace medical plan as defined in Section 14.2 of Title 85 of the Oklahoma Statutes;

~~5.~~ 6. "Out-of-network" or "point-of-service" plan is a product issued by a managed care plan that provides additional coverage or

access to services by a health care provider who is not a member of the plan's provider network;

~~6.~~ 7. "Participating provider" means a physician as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan;

~~7.~~ 8. "Provider network" means those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services to eligible individuals enrolled in the plan;

~~8.~~ 9. "Qualified utilization review program" means a utilization review program that meets the requirements of the Oklahoma Managed Care Act; and

~~9.~~ 10. "Urgent care" means the treatment for an unexpected illness or injury which is severe or painful enough to require treatment within twenty-four (24) hours.

SECTION 3. AMENDATORY Section 2, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2528.2), is amended to read as follows:

Section 2528.2 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 1 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 rules established pursuant to Section 4 of this act; 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 4. AMENDATORY Section 4, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2528.4), is amended to read as follows:

Section 2528.4 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 2528.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Health shall coordinate with the Insurance Commissioner and promulgate rules for internal review procedures for health benefit plans subject to the licensure or regulation by the State Department of Health which are consistent with the provisions of Section 1 of this act.

SECTION 6. This act shall become effective November 1, 2000.

47-2-15354 JB 6/11/15