

STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

SENATE BILL 1509

By: Fisher

AS INTRODUCED

An Act relating to public health and safety; creating the Health Benefits Plan Internal Appeals Act; stating short title; defining terms; requiring two levels of appeal; allowing expedited appeal or reversal of adverse determinations; requiring written record in appeal register; stating certain parameters with regard to specified review of adverse determination; stating required contents of appeal register; specifying accessibility of register; requiring State Department of Health to annually examine appeal register; requiring appeal register be retained for specified period; requiring reports and specifying contents; requiring development and use of specified written procedures for appeals; requiring establishment of appeal process as a remedy; allowing submission of appeal by specified persons; requiring health benefit plan to conduct certain review; exempting such review from appeals register reporting requirements; requiring that majority of persons reviewing appeal are health care professionals; requiring specified notification; providing procedures for appeals; stating required contents of appeal decision; requiring establishment of second level appeal process and stating procedures thereof; requiring rendering of appeal decision be expedited in case of an emergency; 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 2529.1 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 "Health Benefit Plan Internal Appeals Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

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

2. "Ambulatory review" means a review of utilization of health care services performed or provided in an outpatient setting;

3. "Appeal" means a written or oral request submitted by a covered person or designee regarding an adverse determination;

4. "Appeals procedure" means a formal process whereby a covered person, or a designee, contests an adverse determination rendered by a health benefit plan or its designee utilization review organization which resulted in the denial, reduction or termination of a requested health care service;

5. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

6. "Certification" means a determination by a health benefit plan or its designee utilization review organization that an admission, continued stay or other health care service has been reviewed and, based on the information provided, such admission, continued stay or other health care service satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting and level of care;

7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health benefit plan to determine the necessity and appropriateness of a health care service;

8. "Commissioner" means the State Commissioner of Health;

9. "Covered benefit" or "benefit" means a health care service to which a covered person is entitled under the terms of a health benefit plan;

10. "Covered person" means an individual who receives medical care and treatment pursuant to the provisions of 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;

11. "Department" means the State Department of Health;

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

13. "Discharge planning" means a formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient will receive following discharge from a facility;

14. "Emergency medical condition" means a medical condition based on a patient's presenting symptoms arising from any injury, illness or condition, that is manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. serious jeopardy to the health of the individual,
- b. serious impairment to bodily functions, or
- c. serious dysfunction of any bodily organ or part;

15. "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 benefit plan, a health

maintenance organization, a preferred provider plan, a managed care plan, the Oklahoma State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA), or a self-insured plan. For purposes of this act, the following do not apply to the definition of a health benefit plan:

- a. health benefit plans that do not use a primary care physician-based prior authorization system and that have written procedures that permit external review,
- b. health benefit plans and health care provided pursuant to the provisions of Titles XVIII, XIX or XXI of the federal Social Security Act, and
- c. workers' compensation benefits or coverage subject to the provisions of Title 85 of the Oklahoma Statutes;

16. "Health care professional" means a professional, including a physician engaged in the delivery of health care services, who is licensed or certified, or who practices under other authority consistent with state law;

17. "Health care provider" means any physician, hospital, agency, or other person that is licensed or otherwise authorized in this state to furnish health care services;

18. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review; and

19. "Utilization review organization" means an entity that conducts utilization reviews; provided, however, such reviews shall not include a health carrier's reviews of its own health benefit plan.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

Health benefit plans shall offer two levels of appeal; provided, however, nothing in this act shall prohibit a health benefit plan from offering an expedited appeal or reversing an adverse determination.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan shall maintain a written record of all appeals received during a calendar year in an appeal register. A request for a first level appeal of an adverse determination shall be processed in compliance with the provisions of Section 6 of this act, but shall not be considered an appeal for purposes of the appeal register. A request for a second level appeal of an adverse determination shall be considered an appeal for purposes of the appeal register. For each appeal the register shall contain, at a minimum, the following information:

1. A general description of the reason for the appeal;
2. Date received;
3. Date of each review or hearing;
4. Resolution at each level of the appeal;
5. Date of resolution at each level; and
6. Name of the covered person, or the designee, for whom the appeal was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the State Department of Health.

C. The Department shall annually examine the appeal register of each health benefit plan for the purpose of compiling statistics to be made available to the public. A health benefit plan shall retain the appeal register compiled for any calendar year for a period of

three (3) years or until the Department has adopted a final report of an examination that contains a review of the appeal register for that calendar year, whichever period is longer.

D. A health benefit plan shall submit to the Department, at least annually, a report in a format specified by the Department. The report shall include for each type of health benefit plan offered by the health carrier, the number of covered lives, total number of appeals at the first level, the total number of appeals to the second level, and the number of appeals resolved at each level.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

Except as provided in Section 8 of this act, a health benefit plan shall develop and use written procedures for receiving and resolving appeals from covered persons.

1. A copy of the appeals procedures, including all forms used to process an appeal, shall be filed with the State Department of Health. Any subsequent material modifications to such procedures or forms shall also be filed with the Department.

2. A description of the appeal procedure shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to a covered person or a designee at the time of enrollment or renewal of coverage.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan shall establish a first level appeal process for its managed care plans to give a covered person who is dissatisfied with an adverse determination a remedy to appeal the decision.

B. 1. An appeal involving an adverse determination may be submitted to a health benefit plan by a covered person or a designee.

2. A health benefit plan shall conduct a first level appeal involving an adverse determination. Such appeal shall not be subject to the appeals register reporting requirements contained in Section 4 of this act.

3. A health benefit plan shall ensure that a majority of the persons reviewing an appeal involving an adverse determination are health care professionals.

4. A health benefit plan shall notify a covered person or a designee of the final decision.

C. 1. An appeal concerning an adverse determination may be submitted by a covered person or a designee. A health benefit plan shall issue a written decision to the covered person or designee within sixty (60) calendar days of receipt of such appeal. The person or persons reviewing the appeal shall not be the same person or persons who made the initial decision to deny a claim or who handled the matter that is the subject of the appeal. If the health benefit plan cannot make a decision within sixty (60) calendar days due to circumstances beyond the plan's control, the health benefit plan may take up to an additional twenty (20) calendar days to issue a written decision, if the health benefit plan provides written notice to the covered person or a designee of the extension, and the reasons for the delay, on or before the twentieth calendar day after receiving an appeal.

2. A covered person shall not have the right to attend, or to have a designee in attendance at the first level review.

D. The decision issued pursuant to the procedures provided for in subsections B and C of this section shall contain the following items:

1. A statement of the covered person's appeal from the viewpoint of the reviewer;
2. The reviewer's decision stated in clear terms, and the contract basis or medical rationale for the decision written in sufficient enough detail for the covered person or a designee to respond further to the health benefit plan's position;
3. A reference to the evidence or documentation used as the basis for the decision; and
4. If applicable, a statement indicating:
  - a. a description of the process for obtaining a second level appeal, and
  - b. the written procedures governing a second level appeal, including any required time frame for the review.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan shall establish a second level appeal process to give a covered person who is dissatisfied with a first level appeal decision the option to request a second level appeal of an adverse determination.

B. 1. With respect to such second level review, a health benefit plan shall appoint a second level appeal panel for each appeal. A majority of the second level appeal panel shall be persons who were not previously involved with the first level appeal; provided, however, one person who was previously involved with the first level appeal may be a member of the panel or appear before the panel to present information or answer questions.

2. A health benefit plan shall ensure that a majority of the persons reviewing a second level appeal involving an adverse determination are health care professionals who have appropriate expertise.

3. A health benefit plan shall issue a copy of the written decision regarding an appeal to a health care provider who submits an appeal on behalf of a covered person at either level of appeal.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2529.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

When a physician of a covered person certifies to a health benefit plan in writing that an emergency medical condition exists and that as such, the time frames established by the Health Benefit Plan Internal Appeals Act would jeopardize the life or health of the covered person, the health benefit plan shall render a decision as rapidly as warranted by the condition of the covered person. In no event shall the health benefit plan take more than seventy-two (72) hours to render such decision.

SECTION 9. This act shall become effective January 1, 2001.

47-2-2538 CJ 6/12/2015 1:43:30 AM