ENROLLED SENATE
BILL NO. 1542

By: Monson of the Senate

and

Winchester of the House

An Act relating to insurance and public health and safety; amending 36 O.S. 2001, Section 4405.1, which relates to health benefit plans and credentialing of physicians and other health care providers; amending 63 O.S. 2001, Sections 1-707b, 1-1709.1, 2525.3 and 2525.5, which relate to health care provider credentialing; making provisions applicable to recredentialing; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 4405.1, is amended to read as follows:

Section 4405.1 A. As used in this section:

1. a. "Health benefit plan" or "plan" means:

(1) group hospital or medical insurance coverages,

(2) not-for-profit hospital or medical service or indemnity plans,

(3) prepaid health plans,

(4) health maintenance organizations,

(5) preferred provider plans,

(6) Multiple Employer Welfare Arrangements (MEWA), or

(7) employer self-insured plans that are not exempt pursuant to the federal Employee Retirement Income Security Act (ERISA) provisions, and

b. the term "health benefit plan" shall not include:

(1) individual plans,

(2) plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period

during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance,

(3) Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss),

(4) workers' compensation insurance coverage,

(5) medical payment insurance issued as a part of a motor vehicle insurance policy, or

(6) long-term care policies, including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan; and

2. "Credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health benefit plan. Credentialing or recredentialing may include, but is not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment.

Credentialing or recredentialing is a prerequisite to the final decision of a health benefit plan to permit initial or continued participation by a physician or other health care provider.

B. 1. Any health benefit plan that is offered, issued or renewed in this state shall provide for credentialing and recredentialing of physicians and other health care providers based on criteria provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes.

2. Health benefit plans shall make information on such criteria available to physician and other health care provider applicants, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. Physicians or other health care providers under consideration to provide health care services under a health benefit plan in this state shall apply for credentialing or recredentialing on the uniform credentialing application and shall provide the documentation as outlined in the plan's checklist of materials required in the application process.

C. A health benefit plan shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

D. 1. In reviewing the application, the health benefit plan shall evaluate each application according to the plan's checklist of required materials that accompanies the application.

2. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

3. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health benefit plan. Any malpractice carrier that fails to respond to an inquiry within the time frame may be assessed an administrative penalty by the Insurance Commissioner.

E. 1. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential <u>or recredential</u> a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing <u>or recredentialing</u>.

2. If a plan is unable to credential <u>or recredential</u> a physician or other health care provider due to an application's not being clean, the plan may extend the credentialing <u>or recredentialing</u> process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the reason for the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn. In no event shall the entire credentialing <u>or recredentialing</u> process exceed one hundred eighty (180) calendar days.

3. A health benefit plan shall be prohibited from solely basing a denial of an application for credentialing <u>or recredentialing</u> on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

4. Any health benefit plan that violates the provisions of this section may be assessed an administrative penalty by the Commissioner.

SECTION 2. AMENDATORY 63 O.S. 2001, Section 1-707b, is amended to read as follows:

Section 1-707b. A. The administrator in charge of or the governing board of each hospital licensed by the State Commissioner of Health shall adopt written criteria for use in determining which licensed medical doctors, doctors of osteopathy, doctors of podiatry, and health service psychologists shall be granted professional and/or medical staff privileges by the hospital. A licensed hospital shall not deny an application based solely on the

applicant's license, as long as the applicant is licensed to practice:

1. Medicine by the State Board of Medical Licensure and Supervision;

2. Osteopathy by the State Board of Osteopathy;

3. Podiatry by the State Board of Podiatry; or

4. As a health service psychologist by the Oklahoma State Board of Examiners of Psychologists.

B. The accordance and delineation of medical staff membership or clinical privileges shall be determined on an individual basis commensurate with an applicant's education, training, experience and demonstrated clinical competence.

C. When medical education training and specialty board certification are considerations in the credentialing and recredentialing of physicians, hospitals and health plans shall give equal recognition to those bodies recognized by the federal government for the training and certification of such physicians. Hospitals and health plans shall not discriminate, on the basis of education, against eligible physicians who have:

1. Graduated from medical schools and postdoctoral programs approved by either the American Osteopathic Association or the Accreditation Council for Graduate Medical Education; or

2. Been awarded board eligibility or board certification by specialty boards recognized by either the American Osteopathic Association or the American Board of Medical Specialties.

SECTION 3. AMENDATORY 63 O.S. 2001, Section 1-1709.1, is amended to read as follows:

Section 1-1709.1 A. As used in this section:

1. "Credentialing or recredentialing data" means:

a. the application submitted by a health care professional requesting appointment or reappointment to the medical staff of a health care facility or requesting clinical privileges or other permission to provide health care services at a health care facility,

b. any information submitted by the health care professional in support of such application,

c. any information, unless otherwise privileged, obtained by the health care facility during the credentialing or recredentialing process regarding such application, and

d. the decision made by the health care facility regarding such application;

2. "Credentialing or recredentialing process" means any process, program or proceeding utilized by a health care facility to assess, review, study or evaluate the credentials of a health care professional;

3. "Health care facility" means:

a. any hospital or related institution offering or providing health care services under a license issued pursuant to Section 1-706 of this title, and

b. any ambulatory surgical center offering or providing health care services under a license issued pursuant to Section 2660 of this title;

4. "Health care professional" means any person authorized to practice allopathic medicine and surgery, osteopathic medicine, podiatric medicine, optometry, chiropractic, psychology, dentistry or a dental specialty under a license issued pursuant to Title 59 of the Oklahoma Statutes;

5. "Peer review information" means all records, documents and other information generated during the course of a peer review process, including any reports, statements, memoranda, correspondence, record of proceedings, materials, opinions, findings, conclusions and recommendations, but does not include:

a. the medical records of a patient whose health care in a health care facility is being reviewed,

b. incident reports and other like documents regarding health care services being reviewed, regardless of how the reports or documents are titled or captioned,

c. the identity of any individuals who have personal knowledge regarding the facts and circumstances surrounding the patient's health care in the health care facility,

d. factual statements regarding the patient's health care in the health care facility from any individuals who have personal knowledge regarding the facts and circumstances surrounding the patient's health care, which factual statements were generated outside the peer review process,

e. the identity of all documents and raw data previously created elsewhere and considered during the peer review process,

f. copies of all documents and raw data previously created elsewhere and considered during the peer review process, whether available elsewhere or not, or

g. credentialing or recredentialing data regarding the health care professional who provided the health care services being reviewed or who is the subject of a credentialing or recredentialing process; and

6. "Peer review process" means any process, program or proceeding, including a credentialing or recredentialing process, utilized by a health care facility or county medical society to assess, review, study or evaluate the credentials, competence, professional conduct or health care services of a health care professional.

B. 1. Peer review information shall be private, confidential and privileged:

a. except that a health care facility or county medical society shall be permitted to provide relevant peer review information to the state agency or board which licensed the health care professional who provided the health care services being reviewed in a peer review process or who is the subject of a credentialing or recredentialing process, with notice to the health care professional, and

b. except as provided in subsections C and D of this section.

2. Nothing in this section shall be construed to abrogate, alter or affect any provision in the Oklahoma Statutes which provides that information regarding liability insurance of a health care facility or health care professional is not discoverable or admissible.

C. In any civil action in which a patient or patient's legal representative has alleged that the patient has suffered injuries resulting from negligence by a health care professional in providing health care services to the patient in a health care facility, factual statements, presented during a peer review process utilized by such health care facility, regarding the patient's health care in the health care facility from individuals who have personal knowledge of the facts and circumstances surrounding the patient's health care shall be subject to discovery, pursuant to the Oklahoma Discovery Code, upon an affirmative showing that such statements are not otherwise available in any other manner.

D. 1. In any civil action in which a patient or patient's legal representative has alleged:

a. that the patient has suffered injuries resulting from negligence by a health care professional in providing health care services to the patient in a health care facility, or

b. that the health care facility was independently negligent as a result of permitting the health care professional to provide health care services to the patient in the health care facility,

the recommendations made and action taken as a result of any peer review process utilized by such health care facility regarding the health care professional prior to the date of the alleged negligence shall be subject to discovery pursuant to the Oklahoma Discovery Code.

2. Any information discovered pursuant to this subsection D:

a. shall not be admissible as evidence until a judge or jury has found the health care professional to have been negligent in providing health care services to the patient in such health care facility, and

b. shall not at any time include the identity or means by which to ascertain the identity of any other patient or health care professional.

E. No person involved in a peer review process may be permitted or required to testify regarding the peer review process in any civil proceeding or disclose by responses to written discovery requests any peer review information.

SECTION 4. AMENDATORY 63 O.S. 2001, Section 2525.3, is amended to read as follows:

Section 2525.3 For purposes of the Oklahoma Managed Care Act:

1. "Credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a managed care plan. Credentialing or recredentialing may include, but is not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a managed care plan to permit initial or continued participation by a physician or other health care provider;

2. "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. "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. "Managed care plan" or "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 preferred provider organization (PPO) as defined in Section 6054 of Title 36 of the Oklahoma Statutes, or a certified workplace medical plan as defined in Section 14.2 of Title 85 of the Oklahoma Statutes;

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

9. "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 5. AMENDATORY 63 O.S. 2001, Section 2525.5, is amended to read as follows:

Section 2525.5 A. The rules promulgated by the State Board of Health for managed care plans that conduct business in this state shall at a minimum require that:

1. Enrollees and prospective enrollees in managed care plans shall be provided information on the terms and conditions of the plan in order to make an informed decision about choosing a system of health care delivery. The verbal description of the plan, when presented to enrollees, shall be easily understood and truthful, and shall utilize objective terms. Any written plan description shall be in a readable and understandable format. The plan shall include the following specific items:

a. coverage provisions, benefits, detailed disclosure of pharmacy benefits, including which drugs are on the formulary, and any exclusions by category of service, provider or physician, and if applicable, by specific service,

b. any and all prior authorization or other utilization review requirements, and any procedures that may cause the patient to be denied coverage for or to not be provided a particular service,

c. explanation of how plan limitations affect enrollees, including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services, and

d. enrollee satisfaction statistics including, but not limited to, percent reenrollment and reasons for leaving plans;

2. Plans shall demonstrate that they have adequate access to physicians and other providers, so that all covered health care services will be provided in a timely fashion;

3. Plans shall meet financial requirements established to assure the ability to pay for covered services in a timely fashion;

4. Plans shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures~~,~~; utilization review criteria and procedures~~,~~; quality ~~and~~, credentialing and recredentialing criteria~~,~~; and medical management procedures;

5. a. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application required by Section 1-106.2 of this title with input from physicians and other health care providers.

b. Plans shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

c. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the Council on Optometric Education;

6. a. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

b. A managed care plan shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed;

7. a. In reviewing the application, the managed care plan shall evaluate each application according to the plan's checklist of materials required in the application process.

b. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

c. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a managed care plan. Any malpractice carrier that fails to respond to an inquiry within the time frame may be assessed an administrative penalty by the State Commissioner of Health;

8. a. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this subparagraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack

of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

b. If a plan is unable to credential or recredential a physician or other health care provider due to an application's not being clean, the plan may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

c. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days;

9. a. A managed care plan shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

b. Any managed care plan that violates the provisions of this subsection may be assessed an administrative penalty by the Commissioner;

10. a. Plans shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

b. Plans shall provide, upon request, to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Plans shall not contractually prohibit such requests.

c. No managed care plan shall engage in the practice of medicine or any other profession except as provided by law nor shall a plan include any provision in a provider contract which precludes or discourages a plan's providers from:

(1) informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's plan, or

(2) advocating on behalf of a patient before the managed care plan;

11. Decisions by a managed care plan to authorize or deny coverage for an emergency service shall be based on the 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 health of the patient,

b. impairment of bodily function, or

c. dysfunction of any bodily organ or part;

12. Plans shall not deny an otherwise covered emergency service based solely upon lack of notification to the plan;

13. Plans shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the plan contract;

14. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a plan fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the plan shall not deny coverage for the services due to lack of prior authorization; and

15. The reimbursement policies and patient transfer requirements of a plan shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of a plan is transferred from a hospital emergency department facility to another medical facility, the plan shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

B. Rules promulgated by the Board for qualified utilization review programs shall include, but not be limited to, the following requirements:

1. Prior authorization shall not be required for emergency care;

2. Requests by patients or physicians for nonemergency services shall be answered within five (5) business days of the request;

3. Qualified personnel shall be available for same business day telephone responses to inquiries about medical necessity including certification of continued length of stay;

4. Out-of-area urgent follow-up care will be covered as long as the care:

a. is necessary to stabilize the urgent situation,

b. complies with the managed care plan provisions, and

c. complies with federal guidelines;

5. Plans shall ensure that enrollees, in plans where preauthorization is a condition to coverage of a service, are required to sign medical information release forms upon enrollment for use where services requiring prior authorization are recommended or proposed by their physicians. Plans are prohibited from disclosing to employers any medical information about an enrollee without specific prior authorization from the enrollee. With the exception of insured benefit plans, preauthorization requests may be denied only by a physician licensed by the State Board of Medical Licensure and Supervision or the Oklahoma State Board of Osteopathic Examiners, subject to the jurisdiction of the Oklahoma courts;

6. When prior authorization for a specific service or other specific covered item is obtained, it shall be considered authorization for that purpose, and the specific service shall be considered covered unless there was fraud or incorrect information provided at the time prior authorization was obtained; and

7. Contested denials of service by the attending physician, in cases where there are no medically agreed upon guidelines, shall be evaluated in consultation with physicians of the same or similar specialty or training as the attending physician who is contesting the denial.

SECTION 6. This act shall become effective November 1, 2002.

Passed the Senate the 5th day of March, 2002.

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Presiding Officer of the Senate

Passed the House of Representatives the 22nd day of April, 2002.

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Presiding Officer of the House of Representatives