STATE OF OKLAHOMA

1st Session of the 48th Legislature (2001)

SENATE BILL 676 By: Monson

AS INTRODUCED

An Act relating to public health and safety; amending Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 3, Chapter 292, O.S.L. 2000 (63 O.S. Supp. 2000, Section 2525.5), which relates to rules governing managed care plans; requiring all managed care plans to establish physician credentialing; requiring the plans to make information on physician credentialing criteria available to specified persons; requiring a plan to grant temporary physician credentialing privileges upon completion of specified criteria; providing that the provisions of section of law supersede all other accreditation standards; and providing an effective date.

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

SECTION 1. AMENDATORY Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 3, Chapter 292, O.S.L. 2000 (63 O.S. Supp. 2000, 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:

1. Enrollees and prospective enrollees in health insurance plans shall be provided the terms and conditions of the plan so that they can 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. All written plan descriptions shall be in a readable and understandable format. Specific items that shall be included are:

a. coverage provisions, benefits, detailed disclosure of pharmacy benefits, including which drugs are included 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 lead the patient to be denied coverage for or 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. All 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 criteria, and medical management procedures;

5. a. ~~Physician~~ All plans shall establish physician credentialing ~~shall be~~ based on objective standards, with input from physicians credentialed in the plan~~, which~~. The plans shall ~~be~~ make information on

physician credentialing criteria available to physician applicants and participating physicians.

b. A plan shall grant temporary physician credentialing privileges upon completion of an application and submission and primary source verification of the following additional items:

(1) an active Oklahoma state medical license,

(2) a Drug Enforcement Agency certificate,

(3) an Oklahoma State Bureau of Narcotics and Dangerous Drugs Control certificate,

(4) malpractice insurance coverage,

(5) evidence of hospital privileges,

(6) applicable board certification,

(7) Education Certificate for Foreign Medical Graduates, if applicable, and

(8) a curriculum vitae or resume that includes a work history.

The provisions of this section shall supersede all other accreditation standards.

c. (1) When economic considerations are part of the credentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians.

(2) When graduate medical education is a consideration in the credentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association.

(3) When graduate medical education is considered for optometric physicians, consideration shall be

given for educational accreditation by the Council on Optometric Education.

d. Each application shall be reviewed by a credentialing committee of physicians. The lack of board certification or board eligibility shall not be the only criterion upon which a denial of an application is based.

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

~~c.~~ f. 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.

~~d.~~ g. No managed health 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 health care plan;

6. 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;

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

8. 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;

9. 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

10. 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:

a. shall not be required for emergency care, and

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

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

3. Out-of-area urgent follow-up care will be covered as long as the care is necessitated to stabilize the urgent situation, complies with health plan provisions, and complies with federal guidelines;

4. 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 physician. 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;

5. 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

6. 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 2. This act shall become effective November 1, 2001.

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