

**COMMITTEE AMENDMENT**  
HOUSE OF REPRESENTATIVES  
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1028 \_\_\_\_\_  
Of the printed Bill  
Page \_\_\_\_\_ Section \_\_\_\_\_ Lines \_\_\_\_\_  
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

**AMEND TITLE TO CONFORM TO AMENDMENTS**

Adopted: \_\_\_\_\_

Amendment submitted by: Doug Cox

\_\_\_\_\_

\_\_\_\_\_  
Reading Clerk

1 STATE OF OKLAHOMA

2 1st Session of the 52nd Legislature (2009)

3 PROPOSED COMMITTEE  
4 SUBSTITUTE  
5 FOR  
6 HOUSE BILL NO. 1028

By: Cox

7 PROPOSED COMMITTEE SUBSTITUTE

8 An Act relating to insurance; amending 36 O.S. 2001,  
9 Section 1219, as last amended by Section 2, Chapter  
10 338, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1219),  
11 which relates to time for processing claims;  
12 eliminating certain time for reimbursement of clean  
13 claims covered by other laws; providing certain time  
14 period for notification of certain defects or  
15 improprieties; eliminating certain modification  
16 requirements; modifying entities to whom certain  
17 forms are provided; providing that certain claims are  
18 clean claims; providing for adoption of rules;  
19 prohibiting the requirement of certain data elements;  
20 authorizing modification of number of data elements  
21 by contract; providing effect of inclusion of  
22 additional information; prohibiting waiver, voidance,  
23 or nullification; providing time limit for payment of  
24 claim; providing for payment of entire claim;  
providing payment requirements when entire claim is  
not determined payable; providing for payment of  
claim under audit; providing time limit of payment of  
claim; providing requirements for requests for  
additional information; providing limitation of  
request for additional information; providing remedy  
for noncompliance with request for information;  
providing for recovery of overpayment of claim;  
providing for appeal of overpayment of claim;  
authorizing establishment of process for appeals;  
providing time limit for determination of appeal;  
defining term; providing for specifications contained  
in verification; requiring toll-free telephone  
number; providing hours of operation; requiring  
answering and recording services for after hours;  
allowing declination of eligibility; providing time

1 period for valid verification; requiring reason for  
2 declination of verification; prohibiting waiver,  
3 voidance, or nullification; providing for  
4 preauthorization; providing time limit for submission  
5 of list of services requiring preauthorization;  
6 providing for determination of necessary services;  
7 requiring review and determination of preauthorized  
8 services; providing for issuance of length of stay in  
9 facility if preauthorization required; requiring  
10 toll-free telephone number; providing hours of  
11 operation; requiring answering and recording services  
12 for after hours; prohibiting denial of services if  
13 preauthorization occurs; allowing denial of service  
14 if certain conditions occur; applying provisions to  
15 agents or other persons; prohibiting waiver,  
16 voidance, or nullification; providing for payment and  
17 amount if insurer fails to timely pay claim;  
18 providing penalty for late payment; providing for  
19 accrual of interest on late payment; prohibiting  
20 liability under certain circumstances; requiring  
21 disclosure of payment of penalty; providing for  
22 additional administrative penalties; amending 36 O.S.  
23 2001, Section 6055, as amended by Section 2, Chapter  
24 288, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6055),  
which relates to selection of health care provider by  
the insured; requiring insurer to list provider as a  
payee on any check or negotiable instrument sent to  
the insured for payment of services if the provider  
is outside of the preferred provider organization;  
providing for codification; and providing an  
effective date.

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

20 SECTION 1. AMENDATORY 36 O.S. 2001, Section 1219, as  
21 last amended by Section 2, Chapter 338, O.S.L. 2007 (36 O.S. Supp.  
22 2008, Section 1219), is amended to read as follows:

23 Section 1219. A. ~~In the administration, servicing, or~~  
24 ~~processing of any accident and health insurance policy, every~~

1 ~~insurer shall reimburse all clean claims of an insured, an assignee~~  
2 ~~of the insured, or a health care provider within forty five (45)~~  
3 ~~calendar days after receipt of the claim by the insurer.~~

4 ~~B.~~ As used in this section:

5 1. "Accident and health insurance policy" or "policy" means any  
6 policy, certificate, contract, agreement or other instrument that  
7 provides accident and health insurance, as defined in Section 703 of  
8 this title, to any person in this state, and any subscriber  
9 certificate or any evidence of coverage issued by a health  
10 maintenance organization to any person in this state;

11 2. "Clean claim" means a claim that has no defect or  
12 impropriety, including a lack of any required substantiating  
13 documentation, or particular circumstance requiring special  
14 treatment that impedes prompt payment; and

15 3. "Insurer" means any entity that provides an accident and  
16 health insurance policy in this state, including, but not limited  
17 to, a licensed insurance company, a not-for-profit hospital service  
18 and medical indemnity corporation, a health maintenance  
19 organization, a fraternal benefit society, a multiple employer  
20 welfare arrangement, or any other entity subject to regulation by  
21 the Insurance Commissioner.

22 ~~C.~~ B. If a claim or any portion of a claim is determined to  
23 have defects or improprieties, including a lack of any required  
24 substantiating documentation, or particular circumstance requiring

1 special treatment, the insured, enrollee or subscriber, assignee of  
2 the insured, enrollee or subscriber, and health care provider shall  
3 be notified in writing within forty-five (45) calendar days after  
4 receipt of a claim by the insurer from a health care provider in a  
5 nonelectronic format or thirty (30) calendar days after receipt of  
6 the claim by the insurer from a health care provider in an  
7 electronic format. The written notice shall specify the portion of  
8 the claim that is causing a delay in processing and explain any  
9 additional information or corrections needed. Failure of an insurer  
10 to provide the insured, enrollee or subscriber, assignee of the  
11 insured, enrollee or subscriber, and health care provider with the  
12 notice shall constitute prima facie evidence that the claim will be  
13 paid in accordance with the terms of the policy. Provided, if a  
14 claim is not submitted into the system due to a failure to meet  
15 basic Electronic Data Interchange (EDI) and/or Health Insurance  
16 Portability and Accountability Act (HIPAA) edits, electronic  
17 notification of the failure to the submitter shall be deemed  
18 compliance with this subsection. ~~Provided further, health~~  
19 ~~maintenance organizations shall not be required to notify the~~  
20 ~~insured, enrollee or subscriber, or assignee of the insured,~~  
21 ~~enrollee or subscriber of any claim defect or impropriety.~~

22 D. C. Upon receipt of the additional information or corrections  
23 which led to the claim's being delayed and a determination that the  
24 information is accurate, an insurer shall either pay or deny the

1 claim or a portion of the claim within forty-five (45) calendar  
2 days.

3 ~~E.~~ D. Payment shall be considered made on:

4 1. The date a draft or other valid instrument which is  
5 equivalent to the amount of the payment is placed in the United  
6 States mail in a properly addressed, postpaid envelope; or

7 2. If not so posted, the date of delivery.

8 ~~F.~~ E. An overdue payment shall bear simple interest at the rate  
9 of ten percent (10%) per year.

10 ~~G.~~ F. In the event litigation should ensue based upon such a  
11 claim, the prevailing party shall be entitled to recover a  
12 reasonable attorney fee to be set by the court and taxed as costs  
13 against the party or parties who do not prevail.

14 ~~H.~~ G. The Insurance Commissioner shall develop a standardized  
15 prompt pay form for use by providers in reporting violations of  
16 prompt pay requirements. The form shall include a requirement that  
17 documentation of the reason for the delay in payment or  
18 documentation of proof of payment must be provided within ten (10)  
19 days of the filing of the form. The Commissioner shall provide the  
20 form to ~~health maintenance organizations~~ all insurers and providers.

21 ~~I.~~ H. The provisions of this section shall not apply to the  
22 Oklahoma Life and Health Insurance Guaranty Association or to the  
23 Oklahoma Property and Casualty Insurance Guaranty Association.

24

1           SECTION 2.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 1219A of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4           A. As used in this act, a nonelectronic claim by a physician or  
5 health care provider, other than an institutional provider, is a  
6 clean claim, as defined by Section 1219 of Title 36 of the Oklahoma  
7 Statutes, if the claim is submitted using the Centers for Medicare  
8 and Medicaid Services Form 1500 or, if adopted by the Insurance  
9 Commissioner by rule, a successor to that form developed by the  
10 National Uniform Claim Committee or the successor of the committee.  
11 An electronic claim by a physician or provider, other than an  
12 institutional provider, is a clean claim if the claim is submitted  
13 using the Professional 837 (ASC X12N 837) format or, if adopted by  
14 the Insurance Commissioner by rule, a successor to that format  
15 adopted by the Centers for Medicare and Medicaid Services or the  
16 successor of the centers.

17           B. A nonelectronic claim by an institutional provider is a  
18 clean claim if the claim is submitted using the Centers for  
19 Medicare and Medicaid Services Form UB-04 or, if adopted by the  
20 Insurance Commissioner by rule, a successor to that form developed  
21 by the National Uniform Billing Committee or the successor of the  
22 committee. An electronic claim by an institutional provider is a  
23 clean claim if the claim is submitted using the Institutional 837  
24 (ASC X12N 837) format or, if adopted by the Insurance Commissioner

1 by rule, a successor to that format adopted by the Centers for  
2 Medicare and Medicaid Services or the successor of the centers.

3 C. The Insurance Commissioner may adopt rules that specify the  
4 information that shall be entered into the appropriate fields on the  
5 applicable claim form for a claim to be a clean claim.

6 D. The Insurance Commissioner shall not require any data  
7 element for an electronic claim that is not required in an  
8 electronic transaction set needed to comply with federal law.

9 E. An insurer and a health care provider may agree by contract  
10 to use fewer data elements than are required in an electronic  
11 transaction set needed to comply with federal law.

12 F. An otherwise clean claim submitted by a physician or health  
13 care provider that includes additional fields, data elements,  
14 attachments, or other information not required pursuant to this  
15 section is considered to be a clean claim for the purposes of this  
16 act.

17 G. Except as provided by subsection E of this section, the  
18 provisions of this section shall not be waived, voided, or nullified  
19 by contract.

20 SECTION 3. NEW LAW A new section of law to be codified  
21 in the Oklahoma Statutes as Section 1219B of Title 36, unless there  
22 is created a duplication in numbering, reads as follows:

23 Unless an insurer has requested additional information from a  
24 treating health care provider to determine payment, the insurer, not

1 later than forty-five (45) days after the date an insurer receives a  
2 clean claim from a health care provider in a nonelectronic format or  
3 thirty (30) days after the date an insurer receives a clean claim  
4 from a health care provider that is electronically submitted, the  
5 insurer shall make a determination of whether the claim is payable  
6 and:

7 1. If the insurer determines the entire claim is payable, pay  
8 the total amount of the claim in accordance with the contract  
9 between the health care provider and the insurer;

10 2. If the insurer determines a portion of the claim is payable,  
11 pay the portion of the claim that is not in dispute and notify the  
12 health care provider in writing why the remaining portion of the  
13 claim will not be paid; or

14 3. If the insurer determines that the claim is not payable,  
15 notify the health care provider in writing why the claim will not be  
16 paid.

17 SECTION 4. NEW LAW A new section of law to be codified  
18 in the Oklahoma Statutes as Section 1219C of Title 36, unless there  
19 is created a duplication in numbering, reads as follows:

20 A. Unless an insurer has requested additional information from  
21 a treating health care provider to determine payment, an insurer  
22 that intends to audit a claim submitted by a health care provider  
23 shall pay the charges submitted at one hundred percent (100%) of the  
24 contracted rate on the claim not later than:

1           1. Thirty (30) days after the date the insurer receives the  
2 clean claim from the health care provider if the claim is submitted  
3 electronically; or

4           2. Forty-five (45) days after the date the insurer receives the  
5 clean claim from the health care provider if the claim is submitted  
6 nonelectronically.

7           B. The insurer shall clearly indicate on the explanation of  
8 payment statement in the manner prescribed by the Insurance  
9 Commissioner by rule that the clean claim is being paid at one  
10 hundred percent (100%) of the contracted rate, subject to completion  
11 of the audit.

12           C. If the insurer requests additional information to complete  
13 the audit, the request shall describe with specificity the clinical  
14 information requested and relate only the information the insurer in  
15 good faith can demonstrate is specific to the claim or episode of  
16 care. The insurer shall not request as a part of the audit  
17 information that is not contained, or is not in the process of being  
18 incorporated into, the medical or billing record of the patient  
19 maintained by the health care provider.

20           D. If the health care provider does not supply information  
21 reasonably requested by the insurer in connection with the audit,  
22 the insurer may:

23

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1        1. Notify the provider in writing that the provider must  
2 provide the information not later than forty-five (45) days after  
3 the date of the notice or forfeit the amount of the claim; and

4        2. If the provider does not provide the information required by  
5 this section, recover the amount of the claim.

6        SECTION 5.        NEW LAW        A new section of law to be codified  
7 in the Oklahoma Statutes as Section 1219D of Title 36, unless there  
8 is created a duplication in numbering, reads as follows:

9        A. An insurer may recover an overpayment to a physician or  
10 health care provider if:

11        1. Not later than one hundred eighty (180) days after the date  
12 the physician or provider receives the payment, the insurer provides  
13 written notice of the overpayment to the physician or provider that  
14 includes the basis and specific reasons for the request for recovery  
15 of funds; and

16        2. The physician or provider does not make arrangements for  
17 repayment of the requested funds on or before forty-five (45) days  
18 after the date the physician or provider receives the notice.

19        B. 1. If a physician or health care provider disagrees with a  
20 request for recovery of an overpayment, the insurer shall provide  
21 the physician or provider with an opportunity to appeal, and the  
22 insurer shall not attempt to recover the overpayment until all  
23 appeal rights are exhausted.

24

1           2. The Insurance Commissioner shall establish a process for  
2 appeals and shall promulgate any necessary rules to effectuate a  
3 process for appeals. Each appeal shall be considered and determined  
4 within thirty (30) days of its commencement.

5           SECTION 6.           NEW LAW           A new section of law to be codified  
6 in the Oklahoma Statutes as Section 1219E of Title 36, unless there  
7 is created a duplication in numbering, reads as follows:

8           A. As used in this section, "verification" includes  
9 preauthorization only if preauthorization is a condition for the  
10 verification.

11           B. On the request of a health care provider for verification of  
12 a particular medical care or health care service the health care  
13 provider proposes to provide to a particular patient, the insurer  
14 shall inform the health care provider without delay whether the  
15 service, if provided to that patient, will be paid by the insurer  
16 and shall specify any deductibles, copayments, or coinsurance for  
17 which the insured is responsible.

18           C. An insurer shall have appropriate personnel reasonably  
19 available at a toll-free telephone number to provide a verification  
20 under this section between 6 a.m. and 6 p.m. central time Monday  
21 through Friday on each day that is not a legal holiday and between 9  
22 a.m. and 12 noon central time on Saturday, Sunday and legal  
23 holidays. An insurer shall have a telephone system capable of  
24 accepting or recording incoming phone calls for verifications after

1 6 p.m. central time Monday through Friday and after 12 noon central  
2 time on Saturday, Sunday and legal holidays and responding to each  
3 of those calls on or before the second calendar day after the date  
4 the call is received.

5 D. An insurer may decline to determine eligibility for payment  
6 if the insurer notifies the physician or health care provider that  
7 requested the verification of the specific reason the determination  
8 was not made.

9 E. An insurer may establish a specific period during which the  
10 verification is valid of not less than thirty (30) days.

11 F. An insurer that declines to provide a verification shall  
12 notify the physician or provider that requested the verification of  
13 the specific reason the verification was not provided.

14 G. If an insurer has provided a verification for proposed  
15 medical care or health care services, the insurer shall not deny or  
16 reduce payment to the physician or provider for those medical care  
17 or health care services if provided to the insured on or before  
18 thirty (30) days after the date the verification was provided unless  
19 the physician or provider has materially misrepresented the proposed  
20 medical care or health care services or has substantially failed to  
21 perform the proposed medical care or health care services.

22 H. The provisions of this section shall not be waived, voided  
23 or nullified by contract.

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1           SECTION 7.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 1219F of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4           A. An insurer that uses a preauthorization process for medical  
5 care and health care services shall provide to each health care  
6 provider, not later than twenty-four (24) hours after the first  
7 business day after the date a request is made, a list of medical  
8 care and health care services that require preauthorization and  
9 information concerning the preauthorization process.

10          B. If proposed medical care or health care services require  
11 preauthorization as a condition of the payment by the insurer to a  
12 health care provider under a health insurance policy, the insurer  
13 shall determine whether the medical care or health care services  
14 proposed to be provided to the insured are medically necessary and  
15 appropriate.

16          C. On receipt of a request from a health care provider for  
17 preauthorization, the insurer shall review and issue a determination  
18 indicating whether the proposed medical care or health care services  
19 are preauthorized. The determination shall be issued and  
20 transmitted not later than the third calendar day after the date the  
21 request is received by the insurer.

22          D. If the proposed medical care or health care services involve  
23 inpatient care and the insurer requires preauthorization as a  
24 condition of payment, the insurer shall review the request and issue

1 a length of stay for the admission into a health care facility based  
2 on the recommendation of the physician of the patient or health care  
3 provider and the written medically accepted screening criteria and  
4 review procedures of the insurer. If the proposed medical or health  
5 care services are to be provided to a patient who is an inpatient in  
6 a health care facility at the time the services are proposed, the  
7 insurer shall review the request and issue a determination  
8 indicating whether proposed services are preauthorized within  
9 twenty-four (24) hours of the request by the physician or provider.

10 E. An insurer shall have appropriate personnel reasonably  
11 available at a toll-free telephone number to respond to requests for  
12 a preauthorization between 6 a.m. and 6 p.m. central time Monday  
13 through Friday on each day that is not a legal holiday and between 9  
14 a.m. and 12 noon central time on Saturday, Sunday and legal  
15 holidays. An insurer shall have a telephone system capable of  
16 accepting or recording incoming phone calls for preauthorizations  
17 after 6 p.m. central time Monday through Friday and after 12 noon  
18 central time on Saturday, Sunday and legal holidays and responding  
19 to each of those calls not later than twenty-four (24) hours after  
20 the call is received.

21 F. If an insurer has preauthorized medical care or health care  
22 services, the insurer shall not deny or reduce payment to the  
23 physician or health care provider for those services based on  
24 medical necessity or appropriateness of care unless the physician or

1 provider has materially misrepresented the proposed medical or  
2 health care services or has substantially failed to perform the  
3 proposed medical or health care services.

4 G. This section applies to an agent or other person with whom  
5 an insurer contracts to perform, or to whom the insurer delegates  
6 the performance of, preauthorization of proposed medical or health  
7 care services.

8 H. The provisions of this section shall not be waived, voided  
9 or nullified by contract.

10 SECTION 8. NEW LAW A new section of law to be codified  
11 in the Oklahoma Statutes as Section 1219G of Title 36, unless there  
12 is created a duplication in numbering, reads as follows:

13 A. Except as provided by this section, if a clean claim  
14 submitted to an insurer is payable and the insurer does not  
15 determine that the claim is payable and pay the claim on or before  
16 the date the insurer is required to make determination or  
17 adjudication of the claim, the insurer shall pay the health care  
18 provider making the claim the contracted rate owed on the claim plus  
19 a penalty in the amount of the lesser of:

20 1. Fifty percent (50%) of the difference between the billed  
21 charges, as submitted on the claim, and the contracted rate; or

22 2. One Hundred Thousand Dollars (\$100,000.00).

23 B. If the claim is paid on or after the forty-sixth day and  
24 before the ninety-first day after the date the insurer is required

1 to make a determination or adjudication of the claim, the insurer  
2 shall pay a penalty in the amount of the lesser of:

3 1. One hundred percent (100%) of the difference between the  
4 billed charges, as submitted on the claim, and the contracted rate;  
5 or

6 2. Two Hundred Thousand Dollars (\$200,000.00).

7 C. If the claim is paid on or after the ninety-first day after  
8 the date the insurer is required to make a determination or  
9 adjudication of the claim, the insurer shall pay a penalty computed  
10 under subsection B of this section plus eighteen percent (18%)  
11 annual interest on that amount. Interest pursuant to this  
12 subsection accrues beginning on the date the insurer was required to  
13 pay the claim and ending on the date the claim and the penalty are  
14 paid in full.

15 D. Except as provided by this section, an insurer that  
16 determines that a claim is payable, that pays only a portion of the  
17 amount of the claim on or before the date the insurer is required to  
18 make a determination or adjudication of the claim, and pays the  
19 balance of the contracted rate owed for the claim after that date,  
20 shall pay to the health care provider, in addition to the contracted  
21 amount owed, a penalty on the amount not timely paid in the amount  
22 of the lesser of:

23 1. Fifty percent (50%) of the underpaid amount; or

24 2. One Hundred Thousand Dollars (\$100,000.00).

1 E. If the balance of the claim is paid on or after the forty-  
2 sixth day and before the ninety-first day after the date the insurer  
3 is required to make a determination or adjudication of the claim,  
4 the insurer shall pay a penalty on the balance of the claim in the  
5 amount of the lesser of:

- 6 1. One hundred percent (100%) of the underpaid amount; or
- 7 2. Two Hundred Thousand Dollars (\$200,000.00).

8 F. If the balance of the claim is paid on or after the ninety-  
9 first day after the date the insurer is required to make a  
10 determination or adjudication of the claim, the insurer shall pay a  
11 penalty on the balance of the claim computed under subsection E of  
12 this section plus eighteen percent (18%) annual interest on that  
13 amount. Interest pursuant to this subsection accrues beginning on  
14 the date the insurer was required to pay the claim and ending on the  
15 date the claim and the penalty are paid in full.

16 G. For the purposes of subsections D and E of this section, the  
17 underpaid amount shall be computed on the ratio of the amount  
18 underpaid on the contracted rate to the contracted rate as applied  
19 to the billed charges as submitted on the claim.

20 H. An insurer is not liable for a penalty under this section  
21 if:

- 22 1. The failure to pay the claim is a result of a catastrophic  
23 event that substantially interferes with the normal business  
24 operations of the insurer; or

1        2. The claim was paid, but for less than the contracted rate,  
2 and:

3            a. the health care provider notifies the insurer of the  
4            underpayment after the one-hundred-eightieth day after  
5            the date the underpayment was received, and

6            b. the insurer pays the balance of the claim on or before  
7            the forty-fifth day after the date the insurer  
8            receives the notice.

9            I. Subsection H of this section does not relieve the insurer  
10 of the obligation to pay the remaining unpaid contracted rate owed  
11 the health care provider.

12           J. An insurer that pays a penalty pursuant to this section  
13 shall clearly indicate on the explanation of payment statement in  
14 the manner prescribed by the Insurance Commissioner by rule the  
15 amount of the contracted rate paid and the amount paid as a penalty.

16           K. In addition to any other penalty or remedy authorized by  
17 law, an insurer that violates Section 2 or 3 of this act in  
18 processing more than two percent (2%) of clean claims submitted to  
19 the insurer may be subject to available administrative penalties as  
20 provided for by the administrative rules of the Oklahoma Insurance  
21 Department. The Insurance Commissioner shall have authority to  
22 impose any administrative penalty provided for by the administrative  
23 rules of the Oklahoma Insurance Department. For each day an  
24 administrative penalty is imposed under this subsection, the penalty

1 shall not exceed One Thousand Dollars (\$1,000.00) for each claim  
2 that remains unpaid in violation of Section 2 or 3 of this act. In  
3 determining whether an insurer has processed health care provider  
4 claims in compliance with Section 2 or 3 of this act, the Insurance  
5 Commissioner shall consider paid claims, other than claims that have  
6 been paid under Section 3 of this act, and shall compute a  
7 compliance percentage for physician and provider claims, other than  
8 institutional provider claims, and a compliance percentage for  
9 institutional provider claims.

10 SECTION 9. AMENDATORY 36 O.S. 2001, Section 6055, as  
11 amended by Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2008,  
12 Section 6055), is amended to read as follows:

13 Section 6055. A. Under any accident and health insurance  
14 policy, hereafter renewed or issued for delivery from out of  
15 Oklahoma or in Oklahoma by any insurer and covering an Oklahoma  
16 risk, the services and procedures may be performed by any  
17 practitioner selected by the insured, or the parent or guardian of  
18 the insured if the insured is a minor, if the services and  
19 procedures fall within the licensed scope of practice of the  
20 practitioner providing the same.

21 B. An accident and health insurance policy may:

22 1. Exclude or limit coverage for a particular illness, disease,  
23 injury or condition; but, except for such exclusions or limits,  
24 shall not exclude or limit particular services or procedures that

1 can be provided for the diagnosis and treatment of a covered  
2 illness, disease, injury or condition, if such exclusion or  
3 limitation has the effect of discriminating against a particular  
4 class of practitioner. However, such services and procedures, in  
5 order to be a covered medical expense, must:

- 6 a. be medically necessary,
- 7 b. be of proven efficacy, and
- 8 c. fall within the licensed scope of practice of the  
9 practitioner providing same; and

10 2. Provide for the application of deductibles and copayment  
11 provisions, when equally applied to all covered charges for services  
12 and procedures that can be provided by any practitioner for the  
13 diagnosis and treatment of a covered illness, disease, injury or  
14 condition. This provision shall not be construed to prohibit  
15 differences in deductibles and copayment provisions between  
16 practitioners, hospitals and ambulatory surgical centers who are  
17 participating preferred provider organization providers and  
18 practitioners, hospitals and ambulatory surgical centers who are not  
19 participating in the preferred provider organization, subject to the  
20 following limitations:

- 21 a. the amount of any annual deductible per covered person  
22 or per family for treatment in a hospital or  
23 ambulatory surgical center that is not a preferred  
24 provider shall not exceed three times the amount of a

1 corresponding annual deductible for treatment in a  
2 hospital or ambulatory surgical center that is a  
3 preferred provider,

4 b. if the policy has no deductible for treatment in a  
5 preferred provider hospital or ambulatory surgical  
6 center, the deductible for treatment in a hospital or  
7 ambulatory surgical center that is not a preferred  
8 provider shall not exceed One Thousand Dollars  
9 (\$1,000.00) per covered-person visit,

10 c. the amount of any annual deductible per covered person  
11 or per family treatment, other than inpatient  
12 treatment, by a practitioner that is not a preferred  
13 practitioner shall not exceed three times the amount  
14 of a corresponding annual deductible for treatment,  
15 other than inpatient treatment, by a preferred  
16 practitioner,

17 d. if the policy has no deductible for treatment by a  
18 preferred practitioner, the annual deductible for  
19 treatment received from a practitioner that is not a  
20 preferred practitioner shall not exceed Five Hundred  
21 Dollars (\$500.00) per covered person,

22 e. the percentage amount of any coinsurance to be paid by  
23 an insured to a practitioner, hospital or ambulatory  
24 surgical center that is not a preferred provider shall

1 not exceed by more than thirty (30) percentage points  
2 the percentage amount of any coinsurance payment to be  
3 paid to a preferred provider,

4 f. a practitioner, hospital or ambulatory surgical center  
5 that is not a preferred provider shall disclose to the  
6 insured, in writing, that the insured may be  
7 responsible for:

8 (1) higher coinsurance and deductibles, and

9 (2) practitioner, hospital or ambulatory surgical  
10 center charges which exceed the allowable charges  
11 of a preferred provider, and

12 g. when a referral is made to a nonparticipating hospital  
13 or ambulatory surgical center, the referring  
14 practitioner must disclose in writing to the insured,  
15 any ownership interest in the nonparticipating  
16 hospital or ambulatory surgical center.

17 C. Upon submission of a claim by a practitioner, hospital, home  
18 care agency, or ambulatory surgical center to an insurer on a  
19 uniform health care claim form adopted by the Insurance Commissioner  
20 pursuant to Section 6581 of this title, the insurer shall provide a  
21 timely explanation of benefits to the practitioner, hospital, home  
22 care agency, or ambulatory surgical center regardless of the network  
23 participation status of such person or entity.

1 D. Benefits available under an accident and health insurance  
2 policy, at the option of the insured, shall be assignable to a  
3 practitioner, hospital, home care agency or ambulatory surgical  
4 center who has provided services and procedures which are covered  
5 under the policy. A practitioner, hospital, home care agency or  
6 ambulatory surgical center shall be compensated directly by an  
7 insurer for services and procedures which have been provided when  
8 the following conditions are met:

9 1. Benefits available under a policy have been assigned in  
10 writing by an insured to the practitioner, hospital, home care  
11 agency or ambulatory surgical center;

12 2. A copy of the assignment has been provided by the  
13 practitioner, hospital, home care agency or ambulatory surgical  
14 center to the insurer;

15 3. A claim has been submitted by the practitioner, hospital,  
16 home care agency or ambulatory surgical center to the insurer on a  
17 uniform health insurance claim form adopted by the Insurance  
18 Commissioner pursuant to Section 6581 of this title; and

19 4. A copy of the claim has been provided by the practitioner,  
20 hospital, home care agency or ambulatory surgical center to the  
21 insured.

22 E. The provisions of subsection D of this section shall not  
23 apply to:

24

1 1. Any preferred provider organization (PPO) as defined by  
2 generally accepted industry standards, that contracts with  
3 practitioners that agree to accept the reimbursement available under  
4 the PPO agreement as payment in full and agree not to balance bill  
5 the insured; or

6 2. Any statewide provider network which:

7 a. provides that a practitioner, hospital, home care  
8 agency or ambulatory surgical center who joins the  
9 provider network shall be compensated directly by the  
10 insurer,

11 b. does not have any terms or conditions which have the  
12 effect of discriminating against a particular class of  
13 practitioner,

14 c. allows any practitioner, hospital, home care agency or  
15 ambulatory surgical center, except a practitioner who  
16 has a prior felony conviction, to become a network  
17 provider if said hospital or practitioner is willing  
18 to comply with the terms and conditions of a standard  
19 network provider contract, and

20 d. contracts with practitioners that agree to accept the  
21 reimbursement available under the network agreement as  
22 payment in full and agree not to balance bill the  
23 insured.

1 F. A nonparticipating practitioner, hospital or ambulatory  
2 surgical center may request from an insurer and the insurer shall  
3 supply a good-faith estimate of the allowable fee for a procedure to  
4 be performed upon an insured based upon information regarding the  
5 anticipated medical needs of the insured provided to the insurer by  
6 the nonparticipating practitioner.

7 G. A practitioner shall be equally compensated for covered  
8 services and procedures provided to an insured on the basis of  
9 charges prevailing in the same geographical area or in similar sized  
10 communities for similar services and procedures provided to  
11 similarly ill or injured persons regardless of the branch of the  
12 healing arts to which the practitioner may belong, if:

13 1. The practitioner does not authorize or permit false and  
14 fraudulent advertising regarding the services and procedures  
15 provided by the practitioner; and

16 2. The practitioner does not aid or abet the insured to violate  
17 the terms of the policy.

18 H. Notwithstanding any other provisions of this section, if an  
19 insured elects to receive medical treatment from a provider outside  
20 of a preferred provider organization (PPO) network and if the  
21 medical treatment is provided, upon proper submission of a claim by  
22 the provider, the insurer shall list the provider as a payee on any  
23 check or negotiable instrument sent to the insured for payment of  
24 the services provided.

1        I. Nothing in the Health Care Freedom of Choice Act shall  
2 prohibit an insurer from establishing a preferred provider  
3 organization and a standard participating provider contract  
4 therefor, specifying the terms and conditions, including, but not  
5 limited to, provider qualifications, and alternative levels or  
6 methods of payment that must be met by a practitioner selected by  
7 the insurer as a participating preferred provider organization  
8 provider.

9        ~~I.~~ J. A preferred provider organization, in executing a  
10 contract, shall not, by the terms and conditions of the contract or  
11 internal protocol, discriminate within its network of practitioners  
12 with respect to participation and reimbursement as it relates to any  
13 practitioner who is acting within the scope of the practitioner's  
14 license under the law solely on the basis of such license.

15        ~~J.~~ K. Decisions by an insurer or a preferred provider  
16 organization (PPO) to authorize or deny coverage for an emergency  
17 service shall be based on the patient presenting symptoms arising  
18 from any injury, illness, or condition manifesting itself by acute  
19 symptoms of sufficient severity, including severe pain, such that a  
20 reasonable and prudent layperson could expect the absence of medical  
21 attention to result in serious:

- 22            1. Jeopardy to the health of the patient;
- 23            2. Impairment of bodily function; or
- 24            3. Dysfunction of any bodily organ or part.

1       ~~K.~~ L. An insurer or preferred provider organization (PPO) shall  
2 not deny an otherwise covered emergency service based solely upon  
3 lack of notification to the insurer or PPO.

4       ~~L.~~ M. An insurer or a preferred provider organization (PPO)  
5 shall compensate a provider for patient screening, evaluation, and  
6 examination services that are reasonably calculated to assist the  
7 provider in determining whether the condition of the patient  
8 requires emergency service. If the provider determines that the  
9 patient does not require emergency service, coverage for services  
10 rendered subsequent to that determination shall be governed by the  
11 policy or PPO contract.

12       ~~M.~~ N. Nothing in this act shall be construed as prohibiting an  
13 insurer, preferred provider organization or other network from  
14 determining the adequacy of the size of its network.

15       SECTION 10. This act shall become effective November 1, 2009.

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