

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 1st Session of the 53rd Legislature (2011)

4 COMMITTEE SUBSTITUTE
5 FOR
6 HOUSE BILL NO. 2081

 By: Key

7 COMMITTEE SUBSTITUTE

8
9 An Act relating to insurance; creating the Uniform
10 Health Carrier External Review Act; stating purpose
11 of act; defining terms; specifying act shall apply to
12 all health carriers; providing exceptions; requiring
13 health carriers to notify insured parties of certain
14 external review rights; specifying requirements of
15 notice; authorizing Insurance Commissioner to
16 promulgate certain rules; specifying requests for
17 external review requirements; authorizing
18 Commissioner to prescribe certain forms; authorizing
19 certain requests for reviews of adverse
20 determinations; requiring insured persons to exhaust
21 internal grievance process before external review is
22 allowed; specifying exhaustion requirements; allowing
23 certain retrospective review determinations after
24 exhaustion; specifying procedure for expedited
grievance reviews; requiring independent reviewing
organizations to complete certain process before
conducting external review; requiring independent
review organization to give certain notice;
authorizing certain requests by waiver; authorizing
requests for certain review if requirements are
waived; authorizing requests for certain reviews
after adverse determination; directing Commissioner
to send copy of request to insurer; requiring insurer
to complete certain review; specifying issues to be
reviewed; requiring certain notice; specifying
contents of notice; authorizing Commissioner to order
certain external reviews; providing procedure for
certain external reviews; specifying certain
independent reviewers shall not be bound by previous

1 decision; requiring production of certain
2 information; providing procedure if health carrier
3 fails to provide certain information; specifying
4 independent review requirements; allowing health
5 carrier to reconsider certain determinations;
6 providing procedure for reversed determinations;
7 specifying requirements of independent reviews;
8 requiring decisions within certain time frame;
9 specifying required contents of certain notices;
10 requiring approval of coverage after certain
11 determinations; directing Commissioner to assign
12 independent review organizations randomly; allowing
13 requests for certain external reviews; requiring
14 certain determinations in order to request external
15 reviews; directing health carriers to determine
16 whether certain requests are reviewable; specifying
17 procedure for certain external reviews; directing
18 Commissioner to assign organization to conduct
19 reviews in certain circumstances; providing that
20 independent review organization shall not be bound by
21 prior determinations; directing health carrier to
22 provide certain information to independent review
23 organizations; providing requirements for certain
24 determinations by independent review organizations;
providing that certain determinations by independent
review organizations shall be done within certain
time frame; specifying notice requirements; requiring
health carrier to approve coverage in certain
circumstances; specifying that expedited reviews may
not be provided in certain circumstances; directing
Commissioner to assign certain reviews randomly;
providing procedure to request certain external
review; directing Commissioner to notify health
carrier of certain reviews; requiring health carrier
to conduct certain preliminary review; specifying
requirements of review; directing health carrier to
provide certain notice to insured; specifying
requirements of notice; authorizing Commissioner to
specify certain forms and supporting information in
notice; establishing notice procedure; providing
requirements for the selection of a clinical
reviewer; providing procedure for clinical reviews;
requiring certain report by clinical reviewer;
specifying clinical reviewer report requirements;
specifying information clinical reviewers shall
consider; establishing procedure for decisions

1 reached by a group of clinical reviewers; specifying
2 notice requirements for certain reports; providing
3 that external reviews shall be binding on health
4 carrier; providing that external reviews shall be
5 binding on covered persons; providing exception;
6 prohibiting the filing of requests for reviews of
7 certain adverse determinations; directing
8 Commissioner to approve certain independent review
9 organizations; establishing eligibility requirements
10 for independent review organizations; directing
11 Commissioner to develop certain application forms;
12 providing application procedure for independent
13 review organizations; providing eligibility
14 requirements; authorizing Commissioner to charge an
15 application fee; specifying approval shall be
16 effective for two years; authorizing Commissioner to
17 terminate approval of independent review
18 organizations in certain circumstances; directing
19 Commissioner to maintain list of approved
20 organizations; providing requirements for
21 organizations conducting external reviews;
22 prohibiting independent review organizations from
23 controlling a health benefit plan; prohibiting
24 certain conflicts of interest; establishing
presumption that certain accreditation shall meet
requirements; requiring Commissioner to review
certain accreditation standards; authorizing
acceptance by the Commissioner of certain reviews;
prohibiting the imposition of liability for certain
damages on an independent review organization;
providing exception; requiring independent review
organizations to maintain certain records; directing
independent review organizations to provide certain
report to Commissioner upon request; specifying
contents of report; requiring the retention of
certain records for three years; requiring health
carrier to pay cost of certain external review;
requiring health carriers to include external review
procedures in certain publications; specifying
Commissioner shall provide format for certain
disclosures; specifying required disclosures;
repealing 63 O.S. 2001, Sections 2528.1, 2528.2,
2528.3, 2528.4, 2528.5, 2528.6, 2528.7, 2528.8,
2528.9 and 2528.10, which relate to the Oklahoma
Managed Care External Review Act; providing for

1 codification; providing an effective date; and
2 declaring an emergency.

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

5 SECTION 1. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 6475.1 of Title 36, unless there
7 is created a duplication in numbering, reads as follows:

8 This act shall be known and may be cited as the "Uniform Health
9 Carrier External Review Act".

10 SECTION 2. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 6475.2 of Title 36, unless there
12 is created a duplication in numbering, reads as follows:

13 The purpose of this act is to provide uniform standards for the
14 establishment and maintenance of external review procedures to
15 assure that covered persons have the opportunity for an independent
16 review of an adverse determination or final adverse determination,
17 as defined in this act.

18 SECTION 3. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 6475.3 of Title 36, unless there
20 is created a duplication in numbering, reads as follows:

21 For purposes of this act:

22 1. "Adverse determination" means a determination by a health
23 carrier or its designee utilization review organization that an

1 admission, availability of care, continued stay or other health care
2 service that is a covered benefit has been reviewed and, based upon
3 the information provided, does not meet the health carrier's
4 requirements for medical necessity, appropriateness, health care
5 setting, level of care or effectiveness, and the requested service
6 or payment for the service is therefore denied, reduced or
7 terminated;

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

10 3. "Authorized representative" means:

11 a. a person to whom a covered person has given express
12 written consent to represent the covered person in an
13 external review,

14 b. a person authorized by law to provide substituted
15 consent for a covered person, or

16 c. a family member of the covered person or the covered
17 person's treating health care professional only when
18 the covered person is unable to provide consent;

19 4. "Best evidence" means evidence based on:

20 a. randomized clinical trials,

21 b. if randomized clinical trials are not available,
22 cohort studies or case-control studies,

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1 c. if subparagraphs a and b of this paragraph are not
2 available, case-series, or

3 d. if subparagraphs a, b and c of this paragraph are not
4 available, expert opinion;

5 5. "Case-control study" means a retrospective evaluation of two
6 groups of patients with different outcomes to determine which
7 specific interventions the patients received;

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

11 7. "Case-series" means an evaluation of a series of patients
12 with a particular outcome, without the use of a control group;

13 8. "Certification" means a determination by a health carrier or
14 its designee utilization review organization that an admission,
15 availability of care, continued stay or other health care service
16 has been reviewed and, based on the information provided, satisfies
17 the health carrier's requirements for medical necessity,
18 appropriateness, health care setting, level of care and
19 effectiveness;

20 9. "Clinical review criteria" means the written screening
21 procedures, decision abstracts, clinical protocols and practice
22 guidelines used by a health carrier to determine the necessity and
23 appropriateness of health care services;

1 10. "Cohort study" means a prospective evaluation of two groups
2 of patients with only one group of patients receiving a specific
3 intervention or specific interventions;

4 11. "Commissioner" means the Insurance Commissioner of this
5 state;

6 12. "Concurrent review" means utilization review conducted
7 during a hospital stay or course of treatment of a patient;

8 13. "Covered benefits" or "benefits" means those health care
9 services to which a covered person is entitled under the terms of a
10 health benefit plan;

11 14. "Covered person" means a policyholder, subscriber, enrollee
12 or other individual participating in a health benefit plan;

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

17 16. "Disclose" means to release, transfer or otherwise divulge
18 protected health information to any person other than the individual
19 who is the subject of the protected health information;

20 17. "Emergency medical condition" means the sudden and, at the
21 time, unexpected onset of a health condition or illness that
22 requires immediate medical attention, where failure to provide
23 medical attention would result in a serious impairment to bodily
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1 functions, serious dysfunction of a bodily organ or part, or would
2 place the person's health in serious jeopardy;

3 18. "Emergency services" means health care items and services
4 furnished or required to evaluate and treat an emergency medical
5 condition;

6 19. "Evidence-based standard" means the conscientious, explicit
7 and judicious use of the current best evidence based on the overall
8 systematic review of the research in making decisions about the care
9 of individual patients;

10 20. "Expert opinion" means a belief or an interpretation by
11 specialists with experience in a specific area about the scientific
12 evidence pertaining to a particular service, intervention or
13 therapy;

14 21. "Facility" means an institution providing health care
15 services or a health care setting, including but not limited to
16 hospitals and other licensed inpatient centers, ambulatory surgical
17 or treatment centers, skilled nursing centers, residential treatment
18 centers, diagnostic, laboratory and imaging centers, and
19 rehabilitation and other therapeutic health settings;

20 22. "Final adverse determination" means an adverse
21 determination involving a covered benefit that has been upheld by a
22 health carrier, or its designee utilization review organization, at
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1 the completion of the health carrier's internal grievance process
2 procedures;

3 23. "Health benefit plan" means a policy, contract, certificate
4 or agreement offered or issued by a health carrier to provide,
5 deliver, arrange for, pay for or reimburse any of the costs of
6 health care services;

7 24. "Health care professional" means a physician or other
8 health care practitioner licensed, accredited or certified to
9 perform specified health care services consistent with state law;

10 25. "Health care provider" or "provider" means a health care
11 professional or a facility;

12 26. "Health care services" means services for the diagnosis,
13 prevention, treatment, cure or relief of a health condition,
14 illness, injury or disease;

15 27. "Health carrier" means an entity subject to the insurance
16 laws and regulations of this state, or subject to the jurisdiction
17 of the Commissioner, that contracts or offers to contract to
18 provide, deliver, arrange for, pay for or reimburse any of the costs
19 of health care services, including but not limited to a sickness and
20 accident insurance company, a health maintenance organization, a
21 nonprofit hospital and health service corporation, or any other
22 entity providing a plan of health insurance, health benefits or
23 health care services;

1 28. "Health information" means information or data, whether
2 oral or recorded in any form or medium, and personal facts or
3 information about events or relationships that relates to:

- 4 a. the past, present or future physical, mental, or
5 behavioral health or condition of an individual or a
6 member of the individual's family,
- 7 b. the provision of health care services to an
8 individual, or
- 9 c. payment for the provision of health care services to
10 an individual;

11 29. "Independent review organization" means an entity that
12 conducts independent external reviews of adverse determinations and
13 final adverse determinations;

14 30. "Medical or scientific evidence" means evidence found in
15 the following sources:

- 16 a. peer-reviewed scientific studies published in or
17 accepted for publication by medical journals that meet
18 nationally recognized requirements for scientific
19 manuscripts and that submit most of the published
20 articles for review by experts who are not part of the
21 editorial staff,
- 22 b. peer-reviewed medical literature, including literature
23 relating to therapies reviewed and approved by a

1 qualified institutional review board, biomedical
2 compendia and other medical literature that meet the
3 criteria of the National Institutes of Health's
4 Library of Medicine for indexing in Index Medicus
5 (Medline) and Elsevier Science Ltd. for indexing in
6 Excerpta Medicus (EMBASE),

7 c. medical journals recognized by the Secretary of Health
8 and Human Services under Section 1861(t)(2) of the
9 federal Social Security Act,

10 d. the following standard reference compendia:

11 (1) the American Hospital Formulary Service-Drug
12 Information,

13 (2) Drug Facts and Comparisons,

14 (3) the American Dental Association Accepted Dental
15 Therapeutics, and

16 (4) the United States Pharmacopoeia-Drug Information,

17 e. findings, studies or research conducted by or under
18 the auspices of federal government agencies and
19 nationally recognized federal research institutes,
20 including but not limited to:

21 (1) the federal Agency for Healthcare Research and
22 Quality,

23 (2) the National Institutes of Health,

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- 1 (3) the National Cancer Institute,
2 (4) the National Academy of Sciences,
3 (5) the Centers for Medicare and Medicaid Services,
4 (6) the federal Food and Drug Administration, and
5 (7) any national board recognized by the National
6 Institutes of Health for the purpose of
7 evaluating the medical value of health care
8 services, or

9 f. any other medical or scientific evidence that is
10 comparable to the sources listed in subparagraphs a
11 through e of this paragraph;

12 31. "NAIC" means the National Association of Insurance
13 Commissioners;

14 32. "Person" means an individual, a corporation, a partnership,
15 an association, a joint venture, a joint stock company, a trust, an
16 unincorporated organization, any similar entity or any combination
17 of the foregoing;

18 33. "Prospective review" means utilization review conducted
19 prior to an admission or a course of treatment;

20 34. "Protected health information" means health information:

21 a. that identifies an individual who is the subject of
22 the information, or
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1 b. with respect to which there is a reasonable basis to
2 believe that the information could be used to identify
3 an individual;

4 35. "Randomized clinical trial" means a controlled, prospective
5 study of patients that have been randomized into an experimental
6 group and a control group at the beginning of the study with only
7 the experimental group of patients receiving a specific
8 intervention, which includes study of the groups for variables and
9 anticipated outcomes over time;

10 36. "Retrospective review" means a review of medical necessity
11 conducted after services have been provided to a patient, but does
12 not include the review of a claim that is limited to an evaluation
13 of reimbursement levels, veracity of documentation, accuracy of
14 coding or adjudication for payment;

15 37. "Second opinion" means an opportunity or requirement to
16 obtain a clinical evaluation by a provider other than the one
17 originally making a recommendation for a proposed health care
18 service to assess the clinical necessity and appropriateness of the
19 initial proposed health care service;

20 38. "Utilization review" means a set of formal techniques
21 designed to monitor the use of, or evaluate the clinical necessity,
22 appropriateness, efficacy, or efficiency of, health care services,
23 procedures, or settings. Techniques may include but are not limited

1 to ambulatory review, prospective review, second opinion,
2 certification, concurrent review, case management, discharge
3 planning, or retrospective review; and

4 39. "Utilization review organization" means an entity that
5 conducts utilization review, other than a health carrier performing
6 a review for its own health benefit plans.

7 SECTION 4. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6475.4 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. Except as provided in subsection B of this section, this act
11 shall apply to all health carriers.

12 B. The provisions of this act shall not apply to a policy or
13 certificate that provides coverage only for a specified disease,
14 specified accident or accident-only coverage, credit, dental,
15 disability income, hospital indemnity, long-term care insurance, as
16 defined in Section 4424 of Title 36 of the Oklahoma Statutes, vision
17 care or any other limited supplemental benefit or to a Medicare
18 supplement policy of insurance, as defined in Section 3611.1 of
19 Title 36 of the Oklahoma Statutes, coverage under a plan through
20 Medicare, Medicaid, or the federal employees health benefits
21 program, any coverage issued under Chapter 55 of Title 10, U.S. Code
22 and any coverage issued as supplement to that coverage, any coverage
23 issued as supplemental to liability insurance, workers' compensation

1 or similar insurance, automobile medical-payment insurance or any
2 insurance under which benefits are payable with or without regard to
3 fault, whether written on a group blanket or individual basis.

4 SECTION 5. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 6475.5 of Title 36, unless there
6 is created a duplication in numbering, reads as follows:

7 A. 1. A health carrier shall notify the covered person in
8 writing of the covered person's right to request an external review
9 to be conducted pursuant to Section 8, 9 or 10 of this act and
10 include the appropriate statements and information set forth in
11 subsection B of this section at the same time the health carrier
12 sends written notice of:

13 a. an adverse determination upon completion of the health
14 carrier's utilization review process set forth in
15 Sections 6551 through 6565 of Title 36 of the Oklahoma
16 Statutes, and

17 b. a final adverse determination.

18 2. As part of the written notice required under paragraph 1 of
19 this subsection, a health carrier shall include the following, or
20 substantially equivalent, language: "We have denied your request
21 for the provision of or payment for a health care service or course
22 of treatment. You may have the right to have our decision reviewed
23 by health care professionals who have no association with us if our

1 decision involved making a judgment as to the medical necessity,
2 appropriateness, health care setting, level of care or effectiveness
3 of the health care service or treatment you requested by submitting
4 a request for external review to the Oklahoma Insurance Department".

5 3. The Insurance Commissioner may promulgate any necessary rule
6 providing for the form and content of the notice required under this
7 section.

8 B. 1. The health carrier shall include in the notice required
9 under subsection A of this section:

10 a. for a notice related to an adverse determination, a
11 statement informing the covered person that:

12 (1) if the covered person has a medical condition
13 where the time frame for completion of an
14 expedited review of a grievance involving an
15 adverse determination would seriously jeopardize
16 the life or health of the covered person or would
17 jeopardize the covered person's ability to regain
18 maximum function, the covered person or the
19 covered person's authorized representative may
20 file a request for an expedited external review
21 to be conducted pursuant to Section 9 of this
22 act, or Section 10 of this act if the adverse
23 determination involves a denial of coverage based

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1 on a determination that the recommended or
2 requested health care service or treatment is
3 experimental or investigational and the covered
4 person's treating physician certifies in writing
5 that the recommended or requested health care
6 service or treatment that is the subject of the
7 adverse determination would be significantly less
8 effective if not promptly initiated, at the same
9 time the covered person or the covered person's
10 authorized representative files a request for an
11 expedited review of a grievance involving an
12 adverse determination, but that the independent
13 review organization assigned to conduct the
14 expedited external review will determine whether
15 the covered person shall be required to complete
16 the expedited review of the grievance prior to
17 conducting the expedited external review, and

18 (2) the covered person or the covered person's
19 authorized representative may file a grievance
20 under the health carrier's internal grievance
21 process, but if the health carrier has not issued
22 a written decision to the covered person or the
23 covered person's authorized representative within

1 thirty (30) days following the date the covered
2 person or the covered person's authorized
3 representative files the grievance with the
4 health carrier and the covered person or the
5 covered person's authorized representative has
6 not requested or agreed to a delay, the covered
7 person or the covered person's authorized
8 representative may file a request for external
9 review pursuant to Section 6 of this act and
10 shall be considered to have exhausted the health
11 carrier's internal grievance process for purposes
12 of Section 7 of this act, and

13 b. for a notice related to a final adverse determination,
14 a statement informing the covered person that:

15 (1) if the covered person has a medical condition
16 where the time frame for completion of a standard
17 external review pursuant to Section 8 of this act
18 would seriously jeopardize the life or health of
19 the covered person or would jeopardize the
20 covered person's ability to regain maximum
21 function, the covered person or the covered
22 person's authorized representative may file a
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1 request for an expedited external review pursuant
2 to Section 9 of this act, or

3 (2) if the final adverse determination concerns:

4 (a) an admission, availability of care,
5 continued stay or health care service for
6 which the covered person received emergency
7 services, but has not been discharged from a
8 facility, the covered person or the covered
9 person's authorized representative may
10 request an expedited external review
11 pursuant to Section 9 of this act, or

12 (b) a denial of coverage based on a
13 determination that the recommended or
14 requested health care service or treatment
15 is experimental or investigational, the
16 covered person or the covered person's
17 authorized representative may file a request
18 for a standard external review to be
19 conducted pursuant to Section 10 of this act
20 or if the covered person's treating
21 physician certifies in writing that the
22 recommended or requested health care service
23 or treatment that is the subject of the

1 request would be significantly less
2 effective if not promptly initiated, the
3 covered person or the covered person's
4 authorized representative may request an
5 expedited external review to be conducted
6 under Section 10 of this act.

7 2. In addition to the information to be provided pursuant to
8 paragraph 1 of this subsection, the health carrier shall include a
9 copy of the description of both the standard and expedited external
10 review procedures the health carrier is required to provide pursuant
11 to Section 17 of this act, highlighting the provisions in the
12 external review procedures that give the covered person or the
13 covered person's authorized representative the opportunity to submit
14 additional information and including any forms used to process an
15 external review.

16 3. As part of any forms provided under paragraph 2 of this
17 subsection, the health carrier shall include an authorization form,
18 or other document approved by the Commissioner that complies with
19 the requirements of 45 CFR, Section 164.508, by which the covered
20 person, for purposes of conducting an external review under this
21 act, authorizes the health carrier and the covered person's treating
22 health care provider to disclose protected health information,
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1 including medical records, concerning the covered person that are
2 pertinent to the external review.

3 SECTION 6. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 6475.6 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 A. 1. Except for a request for an expedited external review as
7 set forth in Section 9 of this act, all requests for external review
8 shall be made in writing to the Insurance Commissioner.

9 2. The Commissioner may prescribe by rule the form and content
10 of external review requests required to be submitted under this
11 section.

12 B. A covered person or the covered person's authorized
13 representative may make a request for an external review of an
14 adverse determination or final adverse determination.

15 SECTION 7. NEW LAW A new section of law to be codified
16 in the Oklahoma Statutes as Section 6475.7 of Title 36, unless there
17 is created a duplication in numbering, reads as follows:

18 A. 1. Except as provided in subsection B of this section, a
19 request for an external review pursuant to Section 8, 9 or 10 of
20 this act shall not be made until the covered person has exhausted
21 the health carrier's internal grievance process.

22 2. A covered person shall be considered to have exhausted the
23 health carrier's internal grievance process for purposes of this
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1 section, if the covered person or the covered person's authorized
2 representative:

3 a. has filed a grievance involving an adverse
4 determination, and

5 b. except to the extent the covered person or the covered
6 person's authorized representative requested or agreed
7 to a delay, has not received a written decision on the
8 grievance from the health carrier within thirty (30)
9 days following the date the covered person or the
10 covered person's authorized representative filed the
11 grievance with the health carrier.

12 3. Notwithstanding paragraph 2 of this subsection, a covered
13 person or the covered person's authorized representative may not
14 make a request for an external review of an adverse determination
15 involving a retrospective review determination made pursuant to
16 Sections 6551 through 6565 of Title 36 of the Oklahoma Statutes
17 until the covered person has exhausted the health carrier's internal
18 grievance process.

19 B. 1. a. At the same time a covered person or the covered
20 person's authorized representative files a request for
21 an expedited review of a grievance involving an
22 adverse determination, the covered person or the
23 covered person's authorized representative may file a

1 request for an expedited external review of the
2 adverse determination:

3 (1) under Section 9 of this act if the covered person
4 has a medical condition where the time frame for
5 completion of an expedited review of the
6 grievance involving an adverse determination
7 would seriously jeopardize the life or health of
8 the covered person or would jeopardize the
9 covered person's ability to regain maximum
10 function, or

11 (2) under Section 10 of this act if the adverse
12 determination involves a denial of coverage based
13 on a determination that the recommended or
14 requested health care service or treatment is
15 experimental or investigational and the covered
16 person's treating physician certifies in writing
17 that the recommended or requested health care
18 service or treatment that is the subject of the
19 adverse determination would be significantly less
20 effective if not promptly initiated,

21 b. upon receipt of a request for an expedited external
22 review under subparagraph a of this paragraph, the
23 independent review organization conducting the
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1 external review in accordance with the provisions of
2 Section 9 or 10 of this act shall determine whether
3 the covered person shall be required to complete the
4 expedited review process before it conducts the
5 expedited external review,

6 c. upon a determination made pursuant to subparagraph b
7 of this paragraph that the covered person must first
8 complete the expedited grievance review process, the
9 independent review organization immediately shall
10 notify the covered person and, if applicable, the
11 covered person's authorized representative of this
12 determination and that it will not proceed with the
13 expedited external review set forth in Section 9 of
14 this act until completion of the expedited grievance
15 review process and the covered person's grievance at
16 the completion of the expedited grievance review
17 process remains unresolved.

18 2. A request for an external review of an adverse determination
19 may be made before the covered person has exhausted the health
20 carrier's internal grievance procedures whenever the health carrier
21 agrees to waive the exhaustion requirement.

22 C. If the requirement to exhaust the health carrier's internal
23 grievance procedures is waived under paragraph 2 of subsection B of
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1 this section, the covered person or the covered person's authorized
2 representative may file a request in writing for a standard external
3 review as set forth in Section 8 or 10 of this act.

4 SECTION 8. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 6475.8 of Title 36, unless there
6 is created a duplication in numbering, reads as follows:

7 A. 1. Within four (4) months after the date of receipt of a
8 notice of an adverse determination or final adverse determination
9 pursuant to Section 5 of this act, a covered person or the covered
10 person's authorized representative may file a request for an
11 external review with the Commissioner.

12 2. Within one (1) business day after the date of receipt of a
13 request for external review pursuant to paragraph 1 of this
14 subsection, the Commissioner shall send a copy of the request to the
15 health carrier.

16 B. Within five (5) business days following the date of receipt
17 of the copy of the external review request from the Commissioner
18 under paragraph 2 of subsection A of this section, the health
19 carrier shall complete a preliminary review of the request to
20 determine whether:

21 1. The individual is or was a covered person in the health
22 benefit plan at the time the health care service was requested or,
23 in the case of a retrospective review, was a covered person in the
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UNDERLINED language denotes Amendments to present Statutes.
BOLD FACE CAPITALIZED language denotes Committee Amendments.
~~Strike thru~~ language denotes deletion from present Statutes.

1 health benefit plan at the time the health care service was
2 provided;

3 2. The health care service that is the subject of the adverse
4 determination or the final adverse determination is a covered
5 service under the covered person's health benefit plan, but for a
6 determination by the health carrier that the health care service is
7 not covered because it does not meet the health carrier's
8 requirements for medical necessity, appropriateness, health care
9 setting, level of care or effectiveness;

10 3. The covered person has exhausted the health carrier's
11 internal grievance process unless the covered person is not required
12 to exhaust the health carrier's internal grievance process pursuant
13 to Section 7 of this act; and

14 4. The covered person has provided all the information and
15 forms required to process an external review, including the release
16 form provided under subsection B of Section 5 of this act.

17 C. 1. Within one (1) business day after completion of the
18 preliminary review, the health carrier shall notify the Commissioner
19 and covered person and, if applicable, the covered person's
20 authorized representative in writing whether:

- 21 a. the request is complete, and
- 22 b. the request is eligible for external review.

23 2. If the request:

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1 a. is not complete, the health carrier shall inform the
2 covered person and, if applicable, the covered
3 person's authorized representative and the
4 Commissioner in writing and include in the notice what
5 information or materials are needed to make the
6 request complete, or

7 b. is not eligible for external review, the health
8 carrier shall inform the covered person, if
9 applicable, the covered person's authorized
10 representative and the Commissioner in writing and
11 include in the notice the reasons for its
12 ineligibility.

13 3. a. The Commissioner may specify the form for the health
14 carrier's notice of initial determination under this
15 subsection and any supporting information to be
16 included in the notice.

17 b. The notice of initial determination shall include a
18 statement informing the covered person and, if
19 applicable, the covered person's authorized
20 representative that a health carrier's initial
21 determination that the external review request is
22 ineligible for review may be appealed to the
23 Commissioner.

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1 4. a. The Commissioner may determine that a request is
2 eligible for external review under subsection B of
3 Section 8 of this act notwithstanding a health
4 carrier's initial determination that the request is
5 ineligible and require that it be referred for
6 external review.

7 b. In making a determination under subparagraph a of this
8 paragraph, the Commissioner's decision shall be made
9 in accordance with the terms of the covered person's
10 health benefit plan and shall be subject to all
11 applicable provisions of this act.

12 D. 1. Whenever the Commissioner receives a notice that a
13 request is eligible for external review following the preliminary
14 review conducted pursuant to subsection C of this section, within
15 one (1) business day after the date of receipt of the notice, the
16 Commissioner shall:

17 a. assign an independent review organization from the
18 list of approved independent review organizations
19 compiled and maintained by the Commissioner pursuant
20 to Section 12 of this act to conduct the external
21 review and notify the health carrier of the name of
22 the assigned independent review organization, and
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1 b. notify in writing the covered person and, if
2 applicable, the covered person's authorized
3 representative of the request's eligibility and
4 acceptance for external review.

5 2. In reaching a decision, the assigned independent review
6 organization shall not be bound by any decisions or conclusions
7 reached during the health carrier's utilization review process as
8 set forth in Sections 6551 through 6555 of Title 36 of the Oklahoma
9 Statutes or the health carrier's internal grievance process.

10 3. The Commissioner shall include in the notice provided to the
11 covered person and, if applicable, the covered person's authorized
12 representative a statement that the covered person or the covered
13 person's authorized representative may submit in writing to the
14 assigned independent review organization within five (5) business
15 days following the date of receipt of the notice provided pursuant
16 to paragraph 1 of this subsection additional information that the
17 independent review organization shall consider when conducting the
18 external review. The independent review organization is not required
19 to, but may, accept and consider additional information submitted
20 after five (5) business days.

21 E. 1. Within five (5) business days after the date of receipt
22 of the notice provided pursuant to paragraph 1 of subsection D of
23 this section, the health carrier or its designee utilization review
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1 organization shall provide to the assigned independent review
2 organization the documents and any information considered in making
3 the adverse determination or final adverse determination.

4 2. Except as provided in paragraph 3 of this subsection,
5 failure by the health carrier or its utilization review organization
6 to provide the documents and information within the time specified
7 in paragraph 1 of this subsection shall not delay the conduct of the
8 external review.

9 3. a. If the health carrier or its utilization review
10 organization fails to provide the documents and
11 information within the time specified in paragraph 1
12 of this subsection, the assigned independent review
13 organization may terminate the external review and
14 make a decision to reverse the adverse determination
15 or final adverse determination.

16 b. Within one (1) business day after making the decision
17 under subparagraph a of this paragraph, the
18 independent review organization shall notify the
19 covered person, if applicable, the covered person's
20 authorized representative, the health carrier, and the
21 Commissioner.

22 F. 1. The assigned independent review organization shall
23 review all of the information and documents received pursuant to
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1 subsection E of this section and any other information submitted in
2 writing to the independent review organization by the covered person
3 or the covered person's authorized representative pursuant to
4 paragraph 3 of subsection D of this section.

5 2. Upon receipt of any information submitted by the covered
6 person or the covered person's authorized representative pursuant to
7 paragraph 3 of subsection D of this section, the assigned
8 independent review organization shall within one (1) business day
9 forward the information to the health carrier.

10 G. 1. Upon receipt of the information, if any, required to be
11 forwarded pursuant to paragraph 2 of subsection F of this section,
12 the health carrier may reconsider its adverse determination or final
13 adverse determination that is the subject of the external review.

14 2. Reconsideration by the health carrier of its adverse
15 determination or final adverse determination pursuant to paragraph 1
16 of this subsection shall not delay or terminate the external review.

17 3. The external review may only be terminated if the health
18 carrier decides, upon completion of its reconsideration, to reverse
19 its adverse determination or final adverse determination and provide
20 coverage or payment for the health care service that is the subject
21 of the adverse determination or final adverse determination.

22 4. a. Within one (1) business day after making the decision
23 to reverse its adverse determination or final adverse
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1 determination, as provided in paragraph 3 of this
2 subsection, the health carrier shall notify the
3 covered person, if applicable, the covered person's
4 authorized representative, the assigned independent
5 review organization, and the Commissioner in writing
6 of its decision.

7 b. The assigned independent review organization shall
8 terminate the external review upon receipt of the
9 notice from the health carrier sent pursuant to
10 subparagraph a of this paragraph.

11 H. In addition to the documents and information provided
12 pursuant to subsection E of this section, the assigned independent
13 review organization, to the extent the information or documents are
14 available and the independent review organization considers them
15 appropriate, shall consider the following in reaching a decision:

16 1. The covered person's medical records;

17 2. The attending health care professional's recommendation;

18 3. Consulting reports from appropriate health care
19 professionals and other documents submitted by the health carrier,
20 covered person, the covered person's authorized representative, or
21 the covered person's treating provider;

22 4. The terms of coverage under the covered person's health
23 benefit plan with the health carrier to ensure that the independent
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1 review organization's decision is not contrary to the terms of
2 coverage under the covered person's health benefit plan with the
3 health carrier;

4 5. The most appropriate practice guidelines, which shall
5 include applicable evidence-based standards and may include any
6 other practice guidelines developed by the federal government,
7 national or professional medical societies, boards and associations;

8 6. Any applicable clinical review criteria developed and used
9 by the health carrier or its designee utilization review
10 organization; and

11 7. The opinion of the independent review organization's
12 clinical reviewer or reviewers after considering paragraphs 1
13 through 6 of this subsection to the extent the information or
14 documents are available and the clinical reviewer or reviewers
15 consider appropriate.

16 I. 1. Within forty-five (45) days after the date of receipt of
17 the request for an external review, the assigned independent review
18 organization shall provide written notice of its decision to uphold
19 or reverse the adverse determination or the final adverse
20 determination to:

- 21 a. the covered person,
- 22 b. if applicable, the covered person's authorized
23 representative,

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1 c. the health carrier, and

2 d. the Commissioner.

3 2. The independent review organization shall include in the
4 notice sent pursuant to paragraph 1 of this subsection:

5 a. a general description of the reason for the request
6 for external review,

7 b. the date the independent review organization received
8 the assignment from the Commissioner to conduct the
9 external review,

10 c. the date the external review was conducted,

11 d. the date of its decision,

12 e. the principal reason or reasons for its decision,
13 including what applicable, if any, evidence-based
14 standards were a basis for its decision,

15 f. the rationale for its decision, and

16 g. references to the evidence or documentation, including
17 the evidence-based standards, considered in reaching
18 its decision.

19 3. Upon receipt of a notice of a decision pursuant to paragraph
20 1 of this subsection reversing the adverse determination or final
21 adverse determination, the health carrier immediately shall approve
22 the coverage that was the subject of the adverse determination or
23 final adverse determination.

1 J. The assignment by the Commissioner of an approved
2 independent review organization to conduct an external review in
3 accordance with this section shall be done on a random basis among
4 those approved independent review organizations qualified to conduct
5 the particular external review based on the nature of the health
6 care service that is the subject of the adverse determination or
7 final adverse determination and other circumstances, including
8 conflict of interest concerns pursuant to subsection D of Section 13
9 of this act.

10 SECTION 9. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 6475.9 of Title 36, unless there
12 is created a duplication in numbering, reads as follows:

13 A. Except as provided in subsection F of this section, a
14 covered person or the covered person's authorized representative may
15 make a request for an expedited external review with the
16 Commissioner at the time the covered person receives:

- 17 1. An adverse determination if:
- 18 a. the adverse determination involves a medical condition
 - 19 of the covered person for which the time frame for
 - 20 completion of an expedited internal review of a
 - 21 grievance involving an adverse determination would
 - 22 seriously jeopardize the life or health of the covered
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UNDERLINED language denotes Amendments to present Statutes.
BOLD FACE CAPITALIZED language denotes Committee Amendments.
~~Strike thru~~ language denotes deletion from present Statutes.

1 person or would jeopardize the covered person's
2 ability to regain maximum function, and

- 3 b. the covered person or the covered person's authorized
4 representative has filed a request for an expedited
5 review of a grievance involving an adverse
6 determination; or

7 2. A final adverse determination:

- 8 a. if the covered person has a medical condition where
9 the time frame for completion of a standard external
10 review pursuant to Section 8 of this act would
11 seriously jeopardize the life or health of the covered
12 person or would jeopardize the covered person's
13 ability to regain maximum function, or
14 b. if the final adverse determination concerns an
15 admission, availability of care, continued stay or
16 health care service for which the covered person
17 received emergency services, but has not been
18 discharged from a facility.

19 B. 1. Upon receipt of a request for an expedited external
20 review, the Commissioner immediately shall send a copy of the
21 request to the health carrier.

22 2. Immediately upon receipt of the request pursuant to
23 paragraph 1 of this subsection, the health carrier shall determine

1 whether the request meets the reviewability requirements set forth
2 in subsection B of Section 8 of this act. The health carrier shall
3 immediately notify the Commissioner and the covered person and, if
4 applicable, the covered person's authorized representative of its
5 eligibility determination.

6 3. a. The Commissioner may specify the form for the health
7 carrier's notice of initial determination under this
8 subsection and any supporting information to be
9 included in the notice.

10 b. The notice of initial determination shall include a
11 statement informing the covered person and, if
12 applicable, the covered person's authorized
13 representative that a health carrier's initial
14 determination that an external review request is
15 ineligible for review may be appealed to the
16 Commissioner.

17 4. a. The Commissioner may determine that a request is
18 eligible for external review under subsection B of
19 Section 8 of this act notwithstanding a health
20 carrier's initial determination that the request is
21 ineligible and require that it be referred for
22 external review.

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1 b. In making a determination under subparagraph a of this
2 paragraph, the Commissioner's decision shall be made
3 in accordance with the terms of the covered person's
4 health benefit plan and shall be subject to all
5 applicable provisions of this act.

6 5. Upon receipt of the notice that the request meets the
7 reviewability requirements, the Commissioner immediately shall
8 assign an independent review organization to conduct the expedited
9 external review from the list of approved independent review
10 organizations compiled and maintained by the Commissioner pursuant
11 to Section 12 of this act. The Commissioner shall immediately
12 notify the health carrier of the name of the assigned independent
13 review organization.

14 6. In reaching a decision in accordance with subsection E of
15 this section, the assigned independent review organization shall not
16 be bound by any decisions or conclusions reached during the health
17 carrier's utilization review process as set forth in Sections 6551
18 through 6565 of Title 36 of the Oklahoma Statutes or the health
19 carrier's internal grievance process.

20 C. Upon receipt of the notice from the Commissioner of the name
21 of the independent review organization assigned to conduct the
22 expedited external review pursuant to paragraph 5 of subsection B of
23 this section, the health carrier or its designee utilization review
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1 organization shall provide or transmit all necessary documents and
2 information considered in making the adverse determination or final
3 adverse determination to the assigned independent review
4 organization electronically or by telephone or facsimile or any
5 other available expeditious method.

6 D. In addition to the documents and information provided or
7 transmitted pursuant to subsection C of this section, the assigned
8 independent review organization, to the extent the information or
9 documents are available and the independent review organization
10 considers them appropriate, shall consider the following in reaching
11 a decision:

- 12 1. The covered person's pertinent medical records;
- 13 2. The attending health care professional's recommendation;
- 14 3. Consulting reports from appropriate health care
15 professionals and other documents submitted by the health carrier,
16 covered person, the covered person's authorized representative or
17 the covered person's treating provider;
- 18 4. The terms of coverage under the covered person's health
19 benefit plan with the health carrier to ensure that the independent
20 review organization's decision is not contrary to the terms of
21 coverage under the covered person's health benefit plan with the
22 health carrier;

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1 5. The most appropriate practice guidelines, which shall
2 include evidence-based standards, and may include any other practice
3 guidelines developed by the federal government, national or
4 professional medical societies, boards and associations;

5 6. Any applicable clinical review criteria developed and used
6 by the health carrier or its designee utilization review
7 organization in making adverse determinations; and

8 7. The opinion of the independent review organization's
9 clinical reviewer or reviewers after considering paragraphs 1
10 through 6 of this subsection to the extent the information and
11 documents are available and the clinical reviewer or reviewers
12 consider appropriate.

13 E. 1. As expeditiously as the covered person's medical
14 condition or circumstances require, but in no event more than
15 seventy-two (72) hours after the date of receipt of the request for
16 an expedited external review that meets the reviewability
17 requirements set forth in subsection B of Section 8 of this act, the
18 assigned independent review organization shall:

- 19 a. make a decision to uphold or reverse the adverse
20 determination or final adverse determination, and
- 21 b. notify the covered person, if applicable, the covered
22 person's authorized representative, the health
23 carrier, and the Commissioner of the decision.

1 2. If the notice provided pursuant to paragraph 1 of this
2 subsection was not in writing, within forty-eight (48) hours after
3 the date of providing that notice, the assigned independent review
4 organization shall:

5 a. provide written confirmation of the decision to the
6 covered person, if applicable, the covered person's
7 authorized representative, the health carrier, and the
8 Commissioner, and

9 b. include the information set forth in paragraph 2 of
10 subsection I of Section 8 of this act.

11 3. Upon receipt of the notice of a decision pursuant to
12 paragraph 1 of this subsection reversing the adverse determination
13 or final adverse determination, the health carrier immediately shall
14 approve the coverage that was the subject of the adverse
15 determination or final adverse determination.

16 F. An expedited external review may not be provided for
17 retrospective adverse or final adverse determinations.

18 G. The assignment by the Commissioner of an approved
19 independent review organization to conduct an external review in
20 accordance with this section shall be done on a random basis among
21 those approved independent review organizations qualified to conduct
22 the particular external review based on the nature of the health
23 care service that is the subject of the adverse determination or

1 final adverse determination and other circumstances, including
2 conflict of interest concerns pursuant to subsection D of Section 13
3 of this act.

4 SECTION 10. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 6475.10 of Title 36, unless
6 there is created a duplication in numbering, reads as follows:

7 A. 1. Within four (4) months after the date of receipt of a
8 notice of an adverse determination or final adverse determination
9 pursuant to Section 5 of this act that involves a denial of coverage
10 based on a determination that the health care service or treatment
11 recommended or requested is experimental or investigational, a
12 covered person or the covered person's authorized representative may
13 file a request for external review with the Commissioner.

14 2. a. A covered person or the covered person's authorized
15 representative may make an oral request for an
16 expedited external review of the adverse
17 determination or final adverse determination pursuant
18 to paragraph 1 of this subsection if the covered
19 person's treating physician certifies, in writing,
20 that the recommended or requested health care service
21 or treatment that is the subject of the request would
22 be significantly less effective if not promptly
23 initiated.

1 b. Upon receipt of a request for an expedited external
2 review, the Commissioner immediately shall notify the
3 health carrier.

4 c. (1) Upon notice of the request for expedited external
5 review, the health carrier immediately shall
6 determine whether the request meets the
7 reviewability requirements of subsection B of
8 this section. The health carrier shall
9 immediately notify the Commissioner and the
10 covered person and, if applicable, the covered
11 person's authorized representative of its
12 eligibility determination.

13 (2) The Commissioner may specify the form for the
14 health carrier's notice of initial determination
15 under division (1) of this subparagraph and any
16 supporting information to be included in the
17 notice.

18 (3) The notice of initial determination under
19 division (1) of this subparagraph shall include a
20 statement informing the covered person and, if
21 applicable, the covered person's authorized
22 representative that a health carrier's initial
23 determination that the external review request is

1 ineligible for review may be appealed to the
2 Commissioner.

3 d. (1) The Commissioner may determine that a request is
4 eligible for external review under paragraph 2 of
5 subsection B of this section notwithstanding a
6 health carrier's initial determination the
7 request is ineligible and require that it be
8 referred for external review.

9 (2) In making a determination under division (1) of
10 this subparagraph, the Commissioner's decision
11 shall be made in accordance with the terms of the
12 covered person's health benefit plan and shall be
13 subject to all applicable provisions of this act.

14 e. Upon receipt of the notice that the expedited external
15 review request meets the reviewability requirements of
16 paragraph 2 of subsection B of this section, the
17 Commissioner immediately shall assign an independent
18 review organization to review the expedited request
19 from the list of approved independent review
20 organizations compiled and maintained by the
21 Commissioner pursuant to Section 12 of this act and
22 notify the health carrier of the name of the assigned
23 independent review organization.

1 f. At the time the health carrier receives the notice of
2 the assigned independent review organization pursuant
3 to subparagraph e of this paragraph, the health
4 carrier or its designee utilization review
5 organization shall provide or transmit all necessary
6 documents and information considered in making the
7 adverse determination or final adverse determination
8 to the assigned independent review organization
9 electronically or by telephone or facsimile or any
10 other available expeditious method.

11 B. 1. Except for a request for an expedited external review
12 made pursuant to paragraph 2 of subsection A of this section, within
13 one (1) business day after the date of receipt of the request, the
14 Commissioner receives a request for an external review, the
15 Commissioner shall notify the health carrier.

16 2. Within five (5) business days following the date of receipt
17 of the notice sent pursuant to paragraph 1 of this subsection, the
18 health carrier shall conduct and complete a preliminary review of
19 the request to determine whether:

20 a. the individual is or was a covered person in the
21 health benefit plan at the time the health care
22 service or treatment was recommended or requested or,
23 in the case of a retrospective review, was a covered
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- 1 person in the health benefit plan at the time the
2 health care service or treatment was provided,
- 3 b. the recommended or requested health care service or
4 treatment that is the subject of the adverse
5 determination or final adverse determination:
- 6 (1) is a covered benefit under the covered person's
7 health benefit plan except for the health
8 carrier's determination that the service or
9 treatment is experimental or investigational for
10 a particular medical condition, and
- 11 (2) is not explicitly listed as an excluded benefit
12 under the covered person's health benefit plan
13 with the health carrier,
- 14 c. the covered person's treating physician has certified
15 that one of the following situations is applicable:
- 16 (1) standard health care services or treatments have
17 not been effective in improving the condition of
18 the covered person,
- 19 (2) standard health care services or treatments are
20 not medically appropriate for the covered person,
21 or
- 22 (3) there is no available standard health care
23 service or treatment covered by the health
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1 carrier that is more beneficial than the
2 recommended or requested health care service or
3 treatment described in subparagraph d of this
4 paragraph,

5 d. the covered person's treating physician:

6 (1) has recommended a health care service or
7 treatment that the physician certifies, in
8 writing, is likely to be more beneficial to the
9 covered person, in the physician's opinion, than
10 any available standard health care services or
11 treatments, or

12 (2) who is a licensed, board-certified or board-
13 eligible physician qualified to practice in the
14 area of medicine appropriate to treat the covered
15 person's condition, has certified in writing that
16 scientifically valid studies using accepted
17 protocols demonstrate that the health care
18 service or treatment requested by the covered
19 person that is the subject of the adverse
20 determination or final adverse determination is
21 likely to be more beneficial to the covered
22 person than any available standard health care
23 services or treatments,

1 e. the covered person has exhausted the health carrier's
2 internal grievance process unless the covered person
3 is not required to exhaust the health carrier's
4 internal grievance process pursuant to Section 7 of
5 this act, and

6 f. the covered person has provided all the information
7 and forms required by the Commissioner that are
8 necessary to process an external review, including the
9 release form provided under subsection B of Section 5
10 of this act.

11 C. 1. Within one (1) business day after completion of the
12 preliminary review, the health carrier shall notify the Commissioner
13 and the covered person and, if applicable, the covered person's
14 authorized representative in writing whether:

- 15 a. the request is complete, and
16 b. the request is eligible for external review.

17 2. If the request:

- 18 a. is not complete, the health carrier shall inform in
19 writing the Commissioner and the covered person and,
20 if applicable, the covered person's authorized
21 representative and include in the notice what
22 information or materials are needed to make the
23 request complete, or

1 b. is not eligible for external review, the health
2 carrier shall inform the covered person, the covered
3 person's authorized representative, if applicable, and
4 the Commissioner in writing and include in the notice
5 the reasons for its ineligibility.

6 3. a. The Commissioner may specify the form for the health
7 carrier's notice of initial determination under
8 paragraph 2 of this subsection and any supporting
9 information to be included in the notice.

10 b. The notice of initial determination provided under
11 paragraph 2 of this subsection shall include a
12 statement informing the covered person and, if
13 applicable, the covered person's authorized
14 representative that a health carrier's initial
15 determination that the external review request is
16 ineligible for review may be appealed to the
17 Commissioner.

18 4. a. The Commissioner may determine that a request is
19 eligible for external review under paragraph 2 of
20 subsection B of this section notwithstanding a health
21 carrier's initial determination that the request is
22 ineligible and require that it be referred for
23 external review.

1 b. In making a determination under subparagraph a of this
2 paragraph, the Commissioner's decision shall be made
3 in accordance with the terms of the covered person's
4 health benefit plan and shall be subject to all
5 applicable provisions of this act.

6 5. Whenever a request for external review is determined
7 eligible for external review, the health carrier shall notify the
8 Commissioner and the covered person and, if applicable, the covered
9 person's authorized representative.

10 D. 1. Within one (1) business day after the receipt of the
11 notice from the health carrier that the external review request is
12 eligible for external review pursuant to subparagraph d of paragraph
13 2 of subsection A of this section or paragraph 5 of subsection C of
14 this section, the Commissioner shall:

- 15 a. assign an independent review organization to conduct
16 the external review from the list of approved
17 independent review organizations compiled and
18 maintained by the Commissioner pursuant to Section 12
19 of this act and notify the health carrier of the name
20 of the assigned independent review organization, and
21 b. notify in writing the covered person and, if
22 applicable, the covered person's authorized
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1 representative of the request's eligibility and
2 acceptance for external review.

3 2. The Commissioner shall include in the notice provided to the
4 covered person and, if applicable, the covered person's authorized
5 representative a statement that the covered person or the covered
6 person's authorized representative may submit in writing to the
7 assigned independent review organization within five (5) business
8 days following the date of receipt of the notice provided pursuant
9 to paragraph 1 of this subsection additional information that the
10 independent review organization shall consider when conducting the
11 external review. The independent review organization is not
12 required to, but may, accept and consider additional information
13 submitted after five (5) business days.

14 3. Within one (1) business day after the receipt of the notice
15 of assignment to conduct the external review pursuant to paragraph 1
16 of this subsection, the assigned independent review organization
17 shall:

- 18 a. select one or more clinical reviewers, as it
19 determines is appropriate, pursuant to paragraph 4 of
20 this subsection to conduct the external review, and
21 b. based on the opinion of the clinical reviewer, or
22 opinions if more than one clinical reviewer has been
23 selected to conduct the external review, make a

1 decision to uphold or reverse the adverse
2 determination or final adverse determination.

3 4. a. In selecting clinical reviewers pursuant to
4 subparagraph a of paragraph 3 of this subsection, the
5 assigned independent review organization shall select
6 physicians or other health care professionals who meet
7 the minimum qualifications described in Section 13 of
8 this act and, through clinical experience in the past
9 three (3) years, are experts in the treatment of the
10 covered person's condition and knowledgeable about the
11 recommended or requested health care service or
12 treatment.

13 b. Neither the covered person, the covered person's
14 authorized representative, if applicable, nor the
15 health carrier, shall choose or control the choice of
16 the physicians or other health care professionals to
17 be selected to conduct the external review.

18 5. In accordance with subsection H of this section, each
19 clinical reviewer shall provide a written opinion to the assigned
20 independent review organization on whether the recommended or
21 requested health care service or treatment should be covered.

22 6. In reaching an opinion, clinical reviewers are not bound by
23 any decisions or conclusions reached during the health carrier's

1 utilization review process as set forth in Sections 6551 through
2 6565 of Title 36 of the Oklahoma Statutes or the health carrier's
3 internal grievance process.

4 E. 1. Within five (5) business days after the date of receipt
5 of the notice provided pursuant to paragraph 1 of subsection D of
6 this section, the health carrier or its designee utilization review
7 organization shall provide to the assigned independent review
8 organization the documents and any information considered in making
9 the adverse determination or the final adverse determination.

10 2. Except as provided in paragraph 3 of this subsection,
11 failure by the health carrier or its designee utilization review
12 organization to provide the documents and information within the
13 time specified in paragraph 1 of this subsection shall not delay the
14 conduct of the external review.

15 3. a. If the health carrier or its designee utilization
16 review organization has failed to provide the
17 documents and information within the time specified in
18 paragraph 1 of this subsection, the assigned
19 independent review organization may terminate the
20 external review and make a decision to reverse the
21 adverse determination or final adverse determination.

22 b. Immediately upon making the decision under
23 subparagraph a of this paragraph, the independent
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1 review organization shall notify the covered person,
2 the covered person's authorized representative, if
3 applicable, the health carrier, and the Commissioner.

4 F. 1. Each clinical reviewer selected pursuant to subsection D
5 of this section shall review all of the information and documents
6 received pursuant to subsection E of this section and any other
7 information submitted in writing by the covered person or the
8 covered person's authorized representative pursuant to paragraph 2
9 of subsection D of this section.

10 2. Upon receipt of any information submitted by the covered
11 person or the covered person's authorized representative pursuant to
12 paragraph 2 of subsection D of this section, within one (1) business
13 day after the receipt of the information, the assigned independent
14 review organization shall forward the information to the health
15 carrier.

16 G. 1. Upon receipt of the information required to be forwarded
17 pursuant to paragraph 2 of subsection F of this section, the health
18 carrier may reconsider its adverse determination or final adverse
19 determination that is the subject of the external review.

20 2. Reconsideration by the health carrier of its adverse
21 determination or final adverse determination pursuant to paragraph 1
22 of this subsection shall not delay or terminate the external review.
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1 3. The external review may be terminated only if the health
2 carrier decides, upon completion of its reconsideration, to reverse
3 its adverse determination or final adverse determination and provide
4 coverage or payment for the recommended or requested health care
5 service or treatment that is the subject of the adverse
6 determination or final adverse determination.

7 4. a. Immediately upon making the decision to reverse its
8 adverse determination or final adverse determination,
9 as provided in paragraph 3 of this subsection, the
10 health carrier shall notify the covered person, the
11 covered person's authorized representative if
12 applicable, the assigned independent review
13 organization, and the Commissioner in writing of its
14 decision.

15 b. The assigned independent review organization shall
16 terminate the external review upon receipt of the
17 notice from the health carrier sent pursuant to
18 subparagraph a of this paragraph.

19 H. 1. Except as provided in paragraph 3 of this subsection,
20 within twenty (20) days after being selected in accordance with
21 subsection D of this section to conduct the external review, each
22 clinical reviewer shall provide an opinion to the assigned
23 independent review organization pursuant to subsection I of this
24

1 section on whether the recommended or requested health care service
2 or treatment should be covered.

3 2. Except for an opinion provided pursuant to paragraph 3 of
4 this subsection, each clinical reviewer's opinion shall be in
5 writing and include the following information:

- 6 a. a description of the covered person's medical
7 condition,
- 8 b. a description of the indicators relevant to
9 determining whether there is sufficient evidence to
10 demonstrate that the recommended or requested health
11 care service or treatment is more likely than not to
12 be beneficial to the covered person than any available
13 standard health care services or treatments and the
14 adverse risks of the recommended or requested health
15 care service or treatment would not be substantially
16 increased over those of available standard health care
17 services or treatments,
- 18 c. a description and analysis of any medical or
19 scientific evidence, as that term is defined in
20 Section 3 of this act, considered in reaching the
21 opinion,

UNDERLINED language denotes Amendments to present Statutes.
BOLD FACE CAPITALIZED language denotes Committee Amendments.
~~Strike thru~~ language denotes deletion from present Statutes.

1 d. a description and analysis of any evidence-based
2 standard, as that term is defined in Section 3 of this
3 act, and

4 e. information on whether the reviewer's rationale for
5 the opinion is based on subparagraph a or b of
6 paragraph 5 of subsection I of this section.

7 3. a. For an expedited external review, each clinical
8 reviewer shall provide an opinion orally or in writing
9 to the assigned independent review organization as
10 expeditiously as the covered person's medical
11 condition or circumstances require, but in no event
12 more than five (5) calendar days after being selected
13 in accordance with subsection D of this section.

14 b. If the opinion provided pursuant to subparagraph a of
15 this paragraph was not in writing, within forty-eight
16 (48) hours following the date the opinion was provided
17 the clinical reviewer shall provide written
18 confirmation of the opinion to the assigned
19 independent review organization and include the
20 information required under paragraph 2 of this
21 subsection.

22 I. In addition to the documents and information provided
23 pursuant to paragraph 2 of subsection A of this section or

1 subsection E of this section, each clinical reviewer selected
2 pursuant to subsection D of this section, to the extent the
3 information or documents are available and the reviewer considers
4 appropriate, shall consider the following in reaching an opinion
5 pursuant to subsection H of this section:

6 1. The covered person's pertinent medical records;

7 2. The attending physician or health care professional's
8 recommendation;

9 3. Consulting reports from appropriate health care
10 professionals and other documents submitted by the health carrier,
11 covered person, the covered person's authorized representative, or
12 the covered person's treating physician or health care professional;

13 4. The terms of coverage under the covered person's health
14 benefit plan with the health carrier to ensure that, but for the
15 health carrier's determination that the recommended or requested
16 health care service or treatment that is the subject of the opinion
17 is experimental or investigational, the reviewer's opinion is not
18 contrary to the terms of coverage under the covered person's health
19 benefit plan with the health carrier; and

20 5. Whether:

21 a. the recommended or requested health care service or
22 treatment has been approved by the federal Food and
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1 Drug Administration, if applicable, for the condition,
2 or

3 b. medical or scientific evidence or evidence-based
4 standards demonstrate that the expected benefits of
5 the recommended or requested health care service or
6 treatment is more likely than not to be beneficial to
7 the covered person than any available standard health
8 care service or treatment and the adverse risks of the
9 recommended or requested health care service or
10 treatment would not be substantially increased over
11 those of available standard health care services or
12 treatments.

13 J. 1. a. Except as provided in subparagraph b of this
14 paragraph, within twenty (20) days after the date it
15 receives the opinion of each clinical reviewer
16 pursuant to subsection I of this section, the assigned
17 independent review organization, in accordance with
18 paragraph 2 of this subsection, shall make a decision
19 and provide written notice of the decision to:

- 20 (1) the covered person,
21 (2) if applicable, the covered person's authorized
22 representative,
23 (3) the health carrier, and

1 (4) the Commissioner.

2 b. (1) For an expedited external review, within forty-
3 eight (48) hours after the date it receives the
4 opinion of each clinical reviewer pursuant to
5 subsection I of this section, the assigned
6 independent review organization, in accordance
7 with paragraph 2 of this subsection, shall make a
8 decision and provide notice of the decision
9 orally or in writing to the persons listed in
10 subparagraph a of this paragraph.

11 (2) If the notice provided under division (1) of this
12 subparagraph was not in writing, within forty-
13 eight (48) hours after the date of providing that
14 notice, the assigned independent review
15 organization shall provide written confirmation
16 of the decision to the persons listed in
17 subparagraph a of this paragraph and include the
18 information set forth in paragraph 3 of this
19 subsection.

20 2. a. If a majority of the clinical reviewers recommend that
21 the recommended or requested health care service or
22 treatment should be covered, the independent review
23 organization shall make a decision to reverse the
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1 health carrier's adverse determination or final
2 adverse determination.

3 b. If a majority of the clinical reviewers recommend that
4 the recommended or requested health care service or
5 treatment should not be covered, the independent
6 review organization shall make a decision to uphold
7 the health carrier's adverse determination or final
8 adverse determination.

9 c. (1) If the clinical reviewers are evenly split as to
10 whether the recommended or requested health care
11 service or treatment should be covered, the
12 independent review organization shall obtain the
13 opinion of an additional clinical reviewer in
14 order for the independent review organization to
15 make a decision based on the opinions of a
16 majority of the clinical reviewers pursuant to
17 subparagraph a or b of this paragraph.

18 (2) The additional clinical reviewer selected under
19 division (1) of this subparagraph shall use the
20 same information to reach an opinion as the
21 clinical reviewers who have already submitted
22 their opinions pursuant to subsection I of this
23 section.

1 (3) The selection of the additional clinical reviewer
2 under this subparagraph shall not extend the time
3 within which the assigned independent review
4 organization is required to make a decision based
5 on the opinions of the clinical reviewers
6 selected pursuant to paragraph 1 of subsection D
7 of this section.

8 3. The independent review organization shall include in the
9 notice provided pursuant to paragraph 1 of this subsection:

- 10 a. a general description of the reason for the request
11 for external review,
- 12 b. the written opinion of each clinical reviewer,
13 including the recommendation of each clinical reviewer
14 as to whether the recommended or requested health care
15 service or treatment should be covered and the
16 rationale for the reviewer's recommendation,
- 17 c. the date the independent review organization was
18 assigned by the Commissioner to conduct the external
19 review,
- 20 d. the date the external review was conducted,
- 21 e. the date of its decision,
- 22 f. the principal reason or reasons for its decision, and
23 g. the rationale for its decision.

1 4. Upon receipt of a notice of a decision pursuant to paragraph
2 1 of this subsection reversing the adverse determination or final
3 adverse determination, the health carrier immediately shall approve
4 coverage of the recommended or requested health care service or
5 treatment that was the subject of the adverse determination or final
6 adverse determination.

7 K. The assignment by the Commissioner of an approved
8 independent review organization to conduct an external review in
9 accordance with this section shall be done on a random basis among
10 those approved independent review organizations qualified to conduct
11 the particular external review based on the nature of the health
12 care service that is the subject of the adverse determination or
13 final adverse determination and other circumstances, including
14 conflict of interest concerns pursuant to subsection D of Section 13
15 of this act.

16 SECTION 11. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 6475.11 of Title 36, unless
18 there is created a duplication in numbering, reads as follows:

19 A. An external review decision is binding on the health carrier
20 except to the extent the health carrier has other remedies available
21 under applicable state law.

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1 B. An external review decision is binding on the covered person
2 except to the extent the covered person has other remedies available
3 under applicable federal or state law.

4 C. A covered person or the covered person's authorized
5 representative shall not file a subsequent request for external
6 review involving the same adverse determination or final adverse
7 determination for which the covered person has already received an
8 external review decision pursuant to this act.

9 SECTION 12. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6475.12 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 A. The Commissioner shall approve independent review
13 organizations eligible to be assigned to conduct external reviews
14 under this act.

15 B. In order to be eligible for approval by the Commissioner
16 under this section to conduct external reviews under this act an
17 independent review organization:

18 1. Except as otherwise provided in this section, shall be
19 accredited by a nationally recognized private accrediting entity
20 that the Commissioner has determined has independent review
21 organization accreditation standards that are equivalent to or
22 exceed the minimum qualifications for independent review
23 organizations established under Section 13 of this act; and

1 2. Shall submit an application for approval in accordance with
2 subsection D of this section.

3 C. The Commissioner shall develop an application form by rule
4 for initially approving and for reapproving independent review
5 organizations to conduct external reviews.

6 D. 1. Any independent review organization wishing to be
7 approved to conduct external reviews under this act shall submit the
8 application form and include with the form all documentation and
9 information necessary for the Commissioner to determine if the
10 independent review organization satisfies the minimum qualifications
11 established under Section 13 of this act.

12 2. a. Subject to subparagraph b of this paragraph, an
13 independent review organization is eligible for
14 approval under this section only if it is accredited
15 by a nationally recognized private accrediting entity
16 that the Commissioner has determined has independent
17 review organization accreditation standards that are
18 equivalent to or exceed the minimum qualifications for
19 independent review organizations under Section 13 of
20 this act.

21 b. The Commissioner may approve independent review
22 organizations that are not accredited by a nationally
23 recognized private accrediting entity if there are no
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1 acceptable nationally recognized private accrediting
2 entities providing independent review organization
3 accreditation.

4 3. The Commissioner may charge an application fee that
5 independent review organizations shall submit to the Commissioner
6 with an application for approval and reapproval.

7 E. 1. An approval is effective for two (2) years, unless the
8 Commissioner determines before its expiration that the independent
9 review organization is not satisfying the minimum qualifications
10 established under Section 13 of this act.

11 2. Whenever the Commissioner determines that an independent
12 review organization has lost its accreditation or no longer
13 satisfies the minimum requirements established under Section 13 of
14 this act, the Commissioner shall terminate the approval of the
15 independent review organization and remove the independent review
16 organization from the list of independent review organizations
17 approved to conduct external reviews under this act that is
18 maintained by the Commissioner pursuant to subsection F of this
19 section.

20 F. The Commissioner shall maintain and periodically update a
21 list of approved independent review organizations.

22 G. The Commissioner may promulgate rules to carry out the
23 provisions of this section.

1 SECTION 13. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6475.13 of Title 36, unless
3 there is created a duplication in numbering, reads as follows:

4 A. To be approved under Section 12 of this act to conduct
5 external reviews, an independent review organization shall have and
6 maintain written policies and procedures that govern all aspects of
7 both the standard external review process and the expedited external
8 review process set forth in this act that include, at a minimum:

9 1. A quality assurance mechanism in place that:

10 a. ensures that external reviews are conducted within the
11 specified time frames and required notices are
12 provided in a timely manner,

13 b. ensures the selection of qualified and impartial
14 clinical reviewers to conduct external reviews on
15 behalf of the independent review organization and
16 suitable matching of reviewers to specific cases and
17 that the independent review organization employs or
18 contracts with an adequate number of clinical
19 reviewers to meet this objective,

20 c. ensures the confidentiality of medical and treatment
21 records and clinical review criteria, and
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~~Strike thru~~ language denotes deletion from present Statutes.

1 d. ensures that any person employed by or under contract
2 with the independent review organization adheres to
3 the requirements of this act;

4 2. A toll-free telephone service to receive information on a
5 twenty-four-hour-a-day, seven-day-a-week basis related to external
6 reviews that is capable of accepting, recording or providing
7 appropriate instruction to incoming telephone callers during other
8 than normal business hours; and

9 3. Agree to maintain and provide to the Commissioner the
10 information set out in Section 15 of this act.

11 B. All clinical reviewers assigned by an independent review
12 organization to conduct external reviews shall be physicians or
13 other appropriate health care providers who meet the following
14 minimum qualifications:

15 1. Be an expert in the treatment of the covered person's
16 medical condition that is the subject of the external review;

17 2. Be knowledgeable about the recommended health care service
18 or treatment through recent or current actual clinical experience
19 treating patients with the same or similar medical condition of the
20 covered person;

21 3. Hold a nonrestricted license in a state of the United States
22 and, for physicians, a current certification by a recognized
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1 American medical specialty board in the area or areas appropriate to
2 the subject of the external review; and

3 4. Have no history of disciplinary actions or sanctions,
4 including loss of staff privileges or participation restrictions,
5 that have been taken or are pending by any hospital, governmental
6 agency or unit, or regulatory body that raise a substantial question
7 as to the clinical reviewer's physical, mental or professional
8 competence or moral character.

9 C. In addition to the requirements set forth in subsection A of
10 this section, an independent review organization may not own or
11 control, be a subsidiary of or in any way be owned or controlled by,
12 or exercise control with a health benefit plan, a national, state or
13 local trade association of health benefit plans, or a national,
14 state or local trade association of health care providers.

15 D. 1. In addition to the requirements set forth in subsections
16 A, B and C of this section, to be approved pursuant to Section 12 of
17 this act to conduct an external review of a specified case, neither
18 the independent review organization selected to conduct the external
19 review nor any clinical reviewer assigned by the independent
20 organization to conduct the external review may have a material
21 professional, familial or financial conflict of interest with any of
22 the following:

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- 1 a. the health carrier that is the subject of the external
2 review,
- 3 b. the covered person whose treatment is the subject of
4 the external review or the covered person's authorized
5 representative,
- 6 c. any officer, director or management employee of the
7 health carrier that is the subject of the external
8 review,
- 9 d. the health care provider, the health care provider's
10 medical group or independent practice association
11 recommending the health care service or treatment that
12 is the subject of the external review,
- 13 e. the facility at which the recommended health care
14 service or treatment would be provided, or
- 15 f. the developer or manufacturer of the principal drug,
16 device, procedure or other therapy being recommended
17 for the covered person whose treatment is the subject
18 of the external review.

19 2. In determining whether an independent review organization or
20 a clinical reviewer of the independent review organization has a
21 material professional, familial or financial conflict of interest
22 for purposes of paragraph 1 of this subsection, the Commissioner
23 shall take into consideration situations where the independent
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1 review organization to be assigned to conduct an external review of
2 a specified case or a clinical reviewer to be assigned by the
3 independent review organization to conduct an external review of a
4 specified case may have an apparent professional, familial or
5 financial relationship or connection with a person described in
6 paragraph 1 of this subsection, but that the characteristics of that
7 relationship or connection are such that they are not a material
8 professional, familial or financial conflict of interest that
9 results in the disapproval of the independent review organization or
10 the clinical reviewer from conducting the external review.

11 E. 1. An independent review organization that is accredited by
12 a nationally recognized private accrediting entity that has
13 independent review accreditation standards that the Commissioner has
14 determined are equivalent to or exceed the minimum qualifications of
15 this section shall be presumed in compliance with this section to be
16 eligible for approval under Section 12 of this act.

17 2. The Commissioner shall initially review and periodically
18 review the independent review organization accreditation standards
19 of a nationally recognized private accrediting entity to determine
20 whether the entity's standards are, and continue to be, equivalent
21 to or exceed the minimum qualifications established under this
22 section. The Commissioner may accept a review conducted by the NAIC
23 for the purpose of the determination under this paragraph.

1 3. Upon request, a nationally recognized private accrediting
2 entity shall make its current independent review organization
3 accreditation standards available to the commissioner or the NAIC in
4 order for the Commissioner to determine if the entity's standards
5 are equivalent to or exceed the minimum qualifications established
6 under this section. The Commissioner may exclude any private
7 accrediting entity that is not reviewed by the NAIC.

8 F. An independent review organization shall be unbiased. An
9 independent review organization shall establish and maintain written
10 procedures to ensure that it is unbiased in addition to any other
11 procedures required under this section.

12 SECTION 14. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 6475.14 of Title 36, unless
14 there is created a duplication in numbering, reads as follows:

15 No independent review organization or clinical reviewer working
16 on behalf of an independent review organization or an employee,
17 agent or contractor of an independent review organization shall be
18 liable in damages to any person for any opinions rendered or acts or
19 omissions performed within the scope of the organization's or
20 person's duties under the law during or upon completion of an
21 external review conducted pursuant to this act, unless the opinion
22 was rendered or act or omission performed in bad faith or involved
23 gross negligence.

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1 SECTION 15. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6475.15 of Title 36, unless
3 there is created a duplication in numbering, reads as follows:

4 A. 1. An independent review organization assigned pursuant to
5 Section 8, 9 or 10 of this act to conduct an external review shall
6 maintain written records in the aggregate by state and by health
7 carrier on all requests for external review for which it conducted
8 an external review during a calendar year and, upon request, submit
9 a report to the Commissioner, as required under paragraph 2 of this
10 subsection.

11 2. Each independent review organization required to maintain
12 written records on all requests for external review pursuant to
13 paragraph 1 of this subsection for which it was assigned to conduct
14 an external review shall submit to the Commissioner, upon request, a
15 report in the format specified by the Commissioner.

16 3. The report shall include in the aggregate by state, and for
17 each health carrier:

- 18 a. the total number of requests for external review,
19 b. the number of requests for external review resolved
20 and, of those resolved, the number resolved upholding
21 the adverse determination or final adverse
22 determination and the number resolved reversing the
23 adverse determination or final adverse determination,

- 1 c. the average length of time for resolution,
- 2 d. a summary of the types of coverages or cases for which
- 3 an external review was sought, as provided in the
- 4 format required by the Commissioner,
- 5 e. the number of external reviews pursuant to subsection
- 6 G of Section 8 of this act that were terminated as the
- 7 result of a reconsideration by the health carrier of
- 8 its adverse determination or final adverse
- 9 determination after the receipt of additional
- 10 information from the covered person or the covered
- 11 person's authorized representative, and
- 12 f. any other information the Commissioner may request or
- 13 require.

14 4. The independent review organization shall retain the written

15 records required pursuant to this subsection for at least three (3)

16 years.

17 B. 1. Each health carrier shall maintain written records in

18 the aggregate, by state and for each type of health benefit plan

19 offered by the health carrier on all requests for external review

20 that the health carrier receives notice of from the Commissioner

21 pursuant to this act.

22 2. Each health carrier required to maintain written records on

23 all requests for external review pursuant to paragraph 1 of this

1 subsection shall submit to the Commissioner, upon request, a report
2 in the format specified by the Commissioner.

3 3. The report shall include in the aggregate, by state, and by
4 type of health benefit plan:

- 5 a. the total number of requests for external review,
- 6 b. from the total number of requests for external review
7 reported under subparagraph a of this paragraph, the
8 number of requests determined eligible for a full
9 external review, and
- 10 c. any other information the Commissioner may request or
11 require.

12 4. The health carrier shall retain the written records required
13 pursuant to this subsection for at least three (3) years.

14 SECTION 16. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 6475.16 of Title 36, unless
16 there is created a duplication in numbering, reads as follows:

17 The health carrier against which a request for a standard
18 external review or an expedited external review is filed shall pay
19 the cost of the independent review organization for conducting the
20 external review.

21 SECTION 17. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 6475.17 of Title 36, unless
23 there is created a duplication in numbering, reads as follows:

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1 A. 1. Each health carrier shall include a description of the
2 external review procedures in or attached to the policy,
3 certificate, membership booklet, outline of coverage or other
4 evidence of coverage it provides to covered persons.

5 2. The disclosure required by paragraph 1 of this subsection
6 shall be in a format prescribed by the Commissioner.

7 B. The description required under subsection A of this section
8 shall include a statement that informs the covered person of the
9 right of the covered person to file a request for an external review
10 of an adverse determination or final adverse determination with the
11 Commissioner. The statement shall explain that external review is
12 available when the adverse determination or final adverse
13 determination involves an issue of medical necessity,
14 appropriateness, health care setting, level of care or
15 effectiveness. The statement shall include the telephone number and
16 address of the Commissioner.

17 C. In addition to subsection B of this section, the statement
18 shall inform the covered person that, when filing a request for an
19 external review, the covered person will be required to authorize
20 the release of any medical records of the covered person that may be
21 required to be reviewed for the purpose of reaching a decision on
22 the external review.

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1 SECTION 18. REPEALER 63 O.S. 2001, Sections 2528.1,
2 2528.2, 2528.3, 2528.4, 2528.5, 2528.6, 2528.7, 2528.8, 2528.9 and
3 2528.10, are hereby repealed.

4 SECTION 19. This act shall become effective July 1, 2011.

5 SECTION 20. It being immediately necessary for the preservation
6 of the public peace, health and safety, an emergency is hereby
7 declared to exist, by reason whereof this act shall take effect and
8 be in full force from and after its passage and approval.

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10 COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 03-07-2011 - DO
11 PASS, As Amended.

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