

1 STATE OF OKLAHOMA

2 2nd Session of the 55th Legislature (2016)

3 HOUSE BILL 2794

By: Griffith

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5  
6 AS INTRODUCED

7 An Act relating to insurance; amending 36 O.S. 2011,  
8 Sections 6475.5, 6475.7 and 6475.9, which relate to  
9 the Uniform Health Carrier External Review Act;  
10 requiring expedited external review procedure;  
11 requiring notice of covered person's right to an  
12 expedited external review; providing the right to an  
13 expedited review under certain circumstances;  
14 exempting a patient from certain internal review  
15 procedures under certain circumstances; modifying  
16 requirements to request a certain expedited review;  
17 and providing an effective date.

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

19 SECTION 1. AMENDATORY 36 O.S. 2011, Section 6475.5, is  
20 amended to read as follows:

21 Section 6475.5 A. 1. A health carrier shall notify the  
22 covered person in writing of the covered person's right to request  
23 an external review to be conducted pursuant to Section 32, 33 or 34  
24 of this act and include the appropriate statements and information  
set forth in subsection B of this section at the same time the  
health carrier sends written notice of:

- 1 a. an adverse determination upon completion of the health  
2 carrier's utilization review process set forth in  
3 Sections 6551 through 6565 of Title 36 of the Oklahoma  
4 Statutes, and  
5 b. a final adverse determination.

6 2. The procedures for external review shall include a procedure  
7 for expedited external review of a denial of prescription drugs or  
8 intravenous infusions for which the patient is receiving benefits  
9 under the health benefit plan. The procedures shall include a  
10 review by a health care provider who:

- 11 a. has not previously reviewed the case, and  
12 b. is of the same or similar specialty as the health care  
13 provider who would typically manage the medical or  
14 dental condition, procedure or treatment under review  
15 in the expedited external review.

16 3. For a covered person who is denied the provision of  
17 prescription drugs or intravenous infusions for which the patient is  
18 receiving benefits under the health benefit plan, the notice  
19 required by this section shall include the covered person's right to  
20 an expedited external review by an independent review organization  
21 and of the procedures to obtain that review.

22 4. As part of the written notice required under paragraph 1 of  
23 this subsection, a health carrier shall include the following, or  
24 substantially equivalent, language: "We have denied your request

1 for the provision of or payment for a health care service or course  
2 of treatment. You may have the right to have our decision reviewed  
3 by health care professionals who have no association with us if our  
4 decision involved making a judgment as to the medical necessity,  
5 appropriateness, health care setting, level of care or effectiveness  
6 of the health care service or treatment you requested by submitting  
7 a request for external review to the Oklahoma Insurance Department."

8 ~~3.~~ 5. The Insurance Commissioner may promulgate any necessary  
9 rule providing for the form and content of the notice required under  
10 this section.

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

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

15 (1) if the covered person has a medical condition  
16 where the time frame for completion of an  
17 expedited review of a grievance involving an  
18 adverse determination would seriously jeopardize  
19 the life or health of the covered person or would  
20 jeopardize the covered person's ability to regain  
21 maximum function, the covered person or the  
22 covered person's authorized representative may  
23 file a request for an expedited external review  
24 to be conducted pursuant to Section 34 of this

1 act, or Section 35 of this act if the adverse  
2 determination involves a denial of coverage based  
3 on a determination that the recommended or  
4 requested health care service or treatment is  
5 experimental or investigational and the covered  
6 person's treating physician certifies in writing  
7 that the recommended or requested health care  
8 service or treatment that is the subject of the  
9 adverse determination would be significantly less  
10 effective if not promptly initiated, at the same  
11 time the covered person or the covered person's  
12 authorized representative files a request for an  
13 expedited review of a grievance involving an  
14 adverse determination, but that the independent  
15 review organization assigned to conduct the  
16 expedited external review will determine whether  
17 the covered person shall be required to complete  
18 the expedited review of the grievance prior to  
19 conducting the expedited external review, and

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

1 covered person's authorized representative within  
2 thirty (30) days following the date the covered  
3 person or the covered person's authorized  
4 representative files the grievance with the  
5 health carrier and the covered person or the  
6 covered person's authorized representative has  
7 not requested or agreed to a delay, the covered  
8 person or the covered person's authorized  
9 representative may file a request for external  
10 review pursuant to Section 30 of this act and  
11 shall be considered to have exhausted the health  
12 carrier's internal grievance process for purposes  
13 of Section 31 of this act, and

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

16 (1) if the covered person has a medical condition  
17 where the time frame for completion of a standard  
18 external review pursuant to Section 32 of this  
19 act would seriously jeopardize the life or health  
20 of the covered person or would jeopardize the  
21 covered person's ability to regain maximum  
22 function, the covered person or the covered  
23 person's authorized representative may file a  
24

1 request for an expedited external review pursuant  
2 to Section 33 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 33 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 34 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  
24 request would be significantly less

1 effective if not promptly initiated, the  
2 covered person or the covered person's  
3 authorized representative may request an  
4 expedited external review to be conducted  
5 under Section 34 of this act.

6 2. In addition to the information to be provided pursuant to  
7 paragraph 1 of this subsection, the health carrier shall include a  
8 copy of the description of both the standard and expedited external  
9 review procedures the health carrier is required to provide pursuant  
10 to Section 41 of this act, highlighting the provisions in the  
11 external review procedures that give the covered person or the  
12 covered person's authorized representative the opportunity to submit  
13 additional information and including any forms used to process an  
14 external review.

15 3. As part of any forms provided under paragraph 2 of this  
16 subsection, the health carrier shall include an authorization form,  
17 or other document approved by the Commissioner that complies with  
18 the requirements of 45 CFR, Section 164.508, by which the covered  
19 person, for purposes of conducting an external review under this  
20 act, authorizes the health carrier and the covered person's treating  
21 health care provider to disclose protected health information,  
22 including medical records, concerning the covered person that are  
23 pertinent to the external review.  
24

1 SECTION 2. AMENDATORY 36 O.S. 2011, Section 6475.7, is  
2 amended to read as follows:

3 Section 6475.7 A. 1. Except as provided in subsection B of  
4 this section, a request for an external review pursuant to Section  
5 42, 43 or 44 of this act shall not be made until the covered person  
6 has exhausted the health carrier's internal grievance process.

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

11 a. has filed a grievance involving an adverse  
12 determination, and

13 b. except to the extent the covered person or the covered  
14 person's authorized representative requested or agreed  
15 to a delay, has not received a written decision on the  
16 grievance from the health carrier within thirty (30)  
17 days following the date the covered person or the  
18 covered person's authorized representative filed the  
19 grievance with the health carrier.

20 3. Notwithstanding paragraph 2 of this subsection, a covered  
21 person or the covered person's authorized representative may not  
22 make a request for an external review of an adverse determination  
23 involving a retrospective review determination made pursuant to  
24 Sections 6551 through 6565 of Title 36 of the Oklahoma Statutes

1 until the covered person has exhausted the health carrier's internal  
2 grievance process.

3 B. 1. a. At the same time a covered person or the covered  
4 person's authorized representative files a request for  
5 an expedited review of a grievance involving an  
6 adverse determination, the covered person or the  
7 covered person's authorized representative may file a  
8 request for an expedited external review of the  
9 adverse determination:

10 (1) under Section 33 of this act if the covered  
11 person has a medical condition where the time  
12 frame for completion of an expedited review of  
13 the grievance involving an adverse determination  
14 would seriously jeopardize the life or health of  
15 the covered person or would jeopardize the  
16 covered person's ability to regain maximum  
17 function, or

18 (2) under Section 34 of this act if the adverse  
19 determination involves a denial of coverage based  
20 on a determination that the recommended or  
21 requested health care service or treatment is  
22 experimental or investigational and the covered  
23 person's treating physician certifies in writing  
24 that the recommended or requested health care

1 service or treatment that is the subject of the  
2 adverse determination would be significantly less  
3 effective if not promptly initiated.

4 b. Upon receipt of a request for an expedited external  
5 review under subparagraph a of this paragraph, the  
6 independent review organization conducting the  
7 external review in accordance with the provisions of  
8 Section 33 or 34 of this act shall determine whether  
9 the covered person shall be required to complete the  
10 expedited review process before it conducts the  
11 expedited external review.

12 c. Upon a determination made pursuant to subparagraph b  
13 of this paragraph that the covered person must first  
14 complete the expedited grievance review process, the  
15 independent review organization immediately shall  
16 notify the covered person and, if applicable, the  
17 covered person's authorized representative of this  
18 determination and that it will not proceed with the  
19 expedited external review set forth in Section 33 of  
20 this act until completion of the expedited grievance  
21 review process and the covered person's grievance at  
22 the completion of the expedited grievance review  
23 process remains unresolved.  
24

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

5           3. In a circumstance involving the provision of prescription  
6 drugs or intravenous infusions for which the patient is receiving  
7 benefits under the health benefit plan, the covered person is:

8           a. entitled to an expedited review to an independent  
9           review organization, and

10          b. not required to comply with procedures for an internal  
11          review of the health carrier or utilization review  
12          agent's adverse determination.

13           C. If the requirement to exhaust the health carrier's internal  
14 grievance procedures is waived under paragraph 2 of subsection B of  
15 this section, the covered person or the covered person's authorized  
16 representative may file a request in writing for a standard external  
17 review as set forth in Section 32 or 34 of this act.

18           SECTION 3.        AMENDATORY        36 O.S. 2011, Section 6475.9, is  
19 amended to read as follows:

20           Section 6475.9 A. Except as provided in subsection F of this  
21 section, a covered person or the covered person's authorized  
22 representative may make a request for an expedited external review  
23 with the Insurance Commissioner at the time the covered person  
24 receives:

1 1. An adverse determination if:

2 a. the adverse determination involves a medical condition  
3 of the covered person for which the time frame for  
4 completion of an expedited internal review of a  
5 grievance involving an adverse determination would  
6 seriously jeopardize the life or health of the covered  
7 person or would jeopardize the covered person's  
8 ability to regain maximum function, ~~and~~

9 b. the adverse determination involves the provision of  
10 prescription drugs or intravenous infusions for which  
11 the patient is receiving benefits under the health  
12 benefits plan, and

13 c. the covered person or the covered person's authorized  
14 representative has filed a request for an expedited  
15 review of a grievance involving an adverse  
16 determination; or

17 2. A final adverse determination:

18 a. if the covered person has a medical condition where  
19 the time frame for completion of a standard external  
20 review pursuant to Section 32 of this act would  
21 seriously jeopardize the life or health of the covered  
22 person or would jeopardize the covered person's  
23 ability to regain maximum function, or  
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1           b.    if the final adverse determination concerns an  
2                   admission, availability of care, continued stay or  
3                   health care service for which the covered person  
4                   received emergency services, but has not been  
5                   discharged from a facility.

6           B.   1.   Upon receipt of a request for an expedited external  
7                   review, the Commissioner immediately shall send a copy of the  
8                   request to the health carrier.

9                   2.   Immediately upon receipt of the request pursuant to  
10                   paragraph 1 of this subsection, the health carrier shall determine  
11                   whether the request meets the reviewability requirements set forth  
12                   in subsection B of Section 32 of this act. The health carrier shall  
13                   immediately notify the Commissioner and the covered person and, if  
14                   applicable, the covered person's authorized representative of its  
15                   eligibility determination.

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

20                   b.   The notice of initial determination shall include a  
21                   statement informing the covered person and, if  
22                   applicable, the covered person's authorized  
23                   representative that a health carrier's initial  
24                   determination that an external review request is

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

3 4. a. The Commissioner may determine that a request is  
4 eligible for external review under subsection B of  
5 Section 32 of this act notwithstanding a health  
6 carrier's initial determination that the request is  
7 ineligible and require that it be referred for  
8 external review.

9 b. In making a determination under subparagraph a of this  
10 paragraph, the Commissioner's decision shall be made  
11 in accordance with the terms of the covered person's  
12 health benefit plan and shall be subject to all  
13 applicable provisions of the Uniform Health Carrier  
14 External Review Act.

15 5. Upon receipt of the notice that the request meets the  
16 reviewability requirements, the Commissioner immediately shall  
17 assign an independent review organization to conduct the expedited  
18 external review from the list of approved independent review  
19 organizations compiled and maintained by the Commissioner pursuant  
20 to Section 36 of this act. The Commissioner shall immediately  
21 notify the health carrier of the name of the assigned independent  
22 review organization.

23 6. In reaching a decision in accordance with subsection E of  
24 this section, the assigned independent review organization shall not

1 be bound by any decisions or conclusions reached during the health  
2 carrier's utilization review process as set forth in Sections 6551  
3 through 6565 of Title 36 of the Oklahoma Statutes or the health  
4 carrier's internal grievance process.

5 C. Upon receipt of the notice from the Commissioner of the name  
6 of the independent review organization assigned to conduct the  
7 expedited external review pursuant to paragraph 5 of subsection B of  
8 this section, the health carrier or its designee utilization review  
9 organization shall provide or transmit all necessary documents and  
10 information considered in making the adverse determination or final  
11 adverse determination to the assigned independent review  
12 organization electronically or by telephone or facsimile or any  
13 other available expeditious method.

14 D. In addition to the documents and information provided or  
15 transmitted pursuant to subsection C of this section, the assigned  
16 independent review organization, to the extent the information or  
17 documents are available and the independent review organization  
18 considers them appropriate, shall consider the following in reaching  
19 a decision:

- 20 1. The covered person's pertinent medical records;
- 21 2. The attending health care professional's recommendation;
- 22 3. Consulting reports from appropriate health care  
23 professionals and other documents submitted by the health carrier,  
24

1 covered person, the covered person's authorized representative or  
2 the covered person's treating provider;

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

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

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

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

20 E. 1. As expeditiously as the covered person's medical  
21 condition or circumstances require, but in no event more than  
22 seventy-two (72) hours after the date of receipt of the request for  
23 an expedited external review that meets the reviewability  
24

1 requirements set forth in subsection B of Section 32 of this act,  
2 the assigned independent review organization shall:

- 3 a. make a decision to uphold or reverse the adverse  
4 determination or final adverse determination, and
- 5 b. notify the covered person, if applicable, the covered  
6 person's authorized representative, the health  
7 carrier, and the Commissioner of the decision.

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

- 12 a. provide written confirmation of the decision to the  
13 covered person, if applicable, the covered person's  
14 authorized representative, the health carrier, and the  
15 Commissioner, and
- 16 b. include the information set forth in paragraph 2 of  
17 subsection I of Section 32 of this act.

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

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

1 G. 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 37  
9 of this act.

10 SECTION 4. This act shall become effective November 1, 2016.

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