STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

SENATE BILL 1409 By: Taylor

AS INTRODUCED

An Act relating to health maintenance organizations; defining terms; allowing certain health benefit plans to make preauthorization exemptions under certain conditions; providing time period for evaluation process; requiring certain health benefit plans publish certain criteria for exemption; requiring certain health benefit plans publish monthly list of providers under exemption; requiring notice upon approval of certain exemption; establishing provisions for denial of certain exemption; providing for reconsideration of exemption eligibility for certain physicians or providers; establishing recission provisions for certain exemption; providing review process for certain recissions; requiring recission for physician be made by certain persons; establishing timeline for effective date of recission under certain circumstances; requiring notice of recission to affected physician or provider; creating appeals process for certain recission determination; allowing for review of determination by independent review organization under certain circumstances; prohibiting retroactive denial of certain health care services due to recission; requiring fees for certain review processes be promulgated by State Board of Medical Licensure and Supervision and State Board of Osteopathic Examiners; prohibiting a denial or reduction in payment by a health benefit plan due to preauthorization exemption, except in certain circumstances; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6890 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purposes of this act:

1. "Health benefit plan" means a health benefit plan offered by a health maintenance organization operating under the Health Maintenance Organization Act of 2003 including a contract between a health benefit plan and a provider to provide to a patient proposed medically necessary and appropriate health care services and Preferred Provider Operations (PPO) as defined pursuant to Section 6054 of Title 36 of the Oklahoma Statutes;

2. "Health care provider" means any physician or hospital that is licensed to provide health care services under the Oklahoma Statutes;

3. "Health care services" means services as defined pursuant to Section 1219.6 of Title 36 of the Oklahoma Statutes;

4. "Independent review organization" means an independent review organization as defined pursuant to Section 6475.3 of Title 36 of the Oklahoma Statutes; and

5. "Prior authorization" means any predetermination, prior authorization, or similar authorization that is verifiable, whether through issuance of letter, facsimile, email, or similar means, indicating that a specific procedure is, or multiple procedures are,

covered under the health benefit plan of a patient and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by health care provider using a format prescribed by the insurer.

B. A health benefit plan that uses a preauthorization process for health care services may exempt a physician or provider from obtaining preauthorization for any health care service if such service is proven to be medically necessary. A health benefit plan shall evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements once every six (6) months. The exemption shall be granted if, in the most recent six-month evaluation period, the health benefit plan has approved or would have approved not less than ninety percent (90%) of the preauthorization requests submitted by the physician or provider for the health care service.

C. A physician or provider is not required to request an exemption from preauthorization to qualify under this act.

D. 1. A health benefit plan that provides any preauthorization exemptions under this act shall post the criteria for such exemptions on a publicly available website. A health benefit plan providing any exemptions under this act shall also post a monthly updated list of health care providers who fall under the exemption.

2. A health benefit plan shall provide notice to a physician or provider that is eligible for a preauthorization exemption no later

than five (5) business days after the determination has been made. The notice shall include:

a. a statement that the physician or provider qualifies for an exemption from preauthorization requirements,

b. a list of health care services and health benefit plans to which the exemption applies,

c. a statement of the duration of the exemption, and

d. a notification of the health benefit plan's payment requirements.

3. Nothing in this subsection shall be construed to authorize a physician or provider to provide a health care service outside of the scope of the physician or provider's applicable license or to require a health benefit plan to pay for a health care service that is performed in violation of the laws of this state.

E. A health benefit plan may deny an exemption from preauthorization only if the physician or provider does not have the exemption at the time of the relevant evaluation period and if the health benefit plan provides the physician or provider with sufficient data for the relevant preauthorization request period that demonstrates that the physician or provider does not meet the criteria for the exemption.

F. If a physician or provider is denied a preauthorization exemption or has the exemption rescinded pursuant to Section 2 of this act, the physician or provider is eligible for consideration of

an exemption for the same health care service immediately after the next evaluation period concludes.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6891 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan that is in compliance with all other provisions of this act may rescind a physician or provider's exemption from preauthorization requirements only during January or June of each year.

B. 1. A health benefit plan shall make the determination to rescind an exemption by using a retrospective review process for the most recent evaluation period. The review shall use a sample chosen at random of not fewer than five (5) and no more than twenty (20) claims submitted by the physician or provider. If findings conclude that less than ninety percent (90%) of the sampled claims for the particular health service met the medical necessity criteria used to previously grant the exemption, the recission process may commence.

2. For a determination to rescind an exemption to be made with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or a similar specialty as the physician under review.

3. A health benefit plan may only conduct a retrospective review of a healthcare service subject to an exemption if:

a. the health benefit plan has a reasonable cause to suspect a basis of denial exists under subsection A of this section, or

b. a review is needed to determine if the physician or provider administering the exemption still qualifies for an exemption under this act; provided, however, that this subparagraph shall not be construed to modify or otherwise affect any other requirements placed upon a health benefit plan except those outlined in Section 3 of this act.

C. 1. A physician or provider's exemption from preauthorization requirements under this section shall remain in effect until thirty (30) days after the health benefit plan notifies the physician or provider of the determination to rescind the exemption if the physician or provider does not appeal the determination. The physician or provider shall be notified not less than twenty-five (25) days before the proposed recission is to take effect. Notice shall include all relevant data and information used to make the determination including, but not limited to, the sample information from the relevant evaluation period and shall include a plain language explanation of the procedures for the physician or provider to appeal the determination.

2. If the physician or provider appeals the determination to rescind the preauthorization exemption, the exemption shall remain

in effect until the fifth day after the date that an independent review organization affirms the determination to rescind the exemption.

D. A physician or provider has the right to a review of a determination regarding the recission of a preauthorization exemption which shall be conducted by an independent review organization. A health benefit plan may not require any other internal appeal process before a physician or provider can request a review of the determination. In requesting a review, the physician or provider may request that the independent review organization consider a different random sample under the same provisions of subsection C of this section.

E. 1. A health benefit plan is bound by an appeal or independent review determination that does not affirm the determination made by the plan to rescind a preauthorization exemption.

2. If a determination regarding a preauthorization exemption made by a health benefit plan is overturned by an independent review organization pursuant to a review, the health benefit plan shall not attempt to rescind the exemption before the end of the next evaluation period.

3. A health benefit plan may not retroactively deny a health care service because of a recission of an exemption under any circumstance.

F. An independent review organization shall complete the review of a determination regarding an exemption recission no later than the thirtieth day after the date that a physician or provider files the request for a review under this section.

G. If a review of a determination by a health benefit plan is conducted pursuant to this section, the health benefit plan shall pay a fee pursuant to Section 19 of Title 76 of the Oklahoma Statutes. The health benefit plan shall pay for the independent review of a determination regarding the preauthorization exemption.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6892 of Title 36, unless there is created a duplication in numbering, reads as follows:

A health benefit plan may not deny or reduce payment to a physician or provider for a health care service for which the physician or provider has been exempted from preauthorization requirements under Section 1 of this act unless the physician or provider:

1. Knowingly or materially misrepresented the health care service in a request for payment submitted to the health benefit plan with the specific intent to deceive or obtain an unlawful payment from the health benefit plan;

2. Failed to substantially perform the healthcare service;

3. Designates the incorrect entity responsible for payment;

4. Has already been paid for the procedures identified in the claim;

5. Submitted the claim fraudulently or the prior authorization was based in whole or part on erroneous information provided to the health benefit plan by the physician or provider, patient, or other person not related to the health benefit plan; or

6. Performs a procedure or service on a patient who was not eligible to receive the procedure or service and the health benefit plan did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

SECTION 4. This act shall become effective January 1, 2023.

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