

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

COMMITTEE SUBSTITUTE

FOR

SENATE BILL 441

By: Garvin

COMMITTEE SUBSTITUTE

An Act relating to prior authorization; creating the Ensuring Transparency in Prior Authorization Act; providing short title; defining terms; requiring certain entities to publish certain criteria on a public website; requiring notice and publication of certain changes to prior authorization process; establishing process for issuance of an adverse determination for certain health care services; providing for appeal process; establishing time period for certain prior authorization determinations; prohibiting revocation of certain approved prior authorization request within certain time period; providing for reduction or denial of payment under certain circumstances; providing for duration of certain prior authorization approvals; requiring utilization review entities to honor certain approved requests for certain time period following enrollment in certain plan; requiring health benefit plans offering pharmacy benefits to accept and respond to certain requests by certain means; providing for approval of certain pending prior authorization requests following certain violations by utilization review entity; providing for codification; and providing an effective date.

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

1 SECTION 1. NEW LAW A new section of law to be codified

2 in the Oklahoma Statutes as Section 6476.1 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 This act shall be known and may be cited as the "Ensuring
5 Transparency in Prior Authorization Act".

6 SECTION 2. NEW LAW A new section of law to be codified

7 in the Oklahoma Statutes as Section 6476.2 of Title 36, unless there
8 is created a duplication in numbering, reads as follows:

9 For the purposes of this act:

10 1. "Adverse determination" means a decision by a utilization
11 review entity on a prior authorization request that the health care
12 services furnished or proposed to be furnished to an enrollee are
13 not medically necessary or are experimental or investigational, and
14 coverage by the health benefit plan is therefore denied, reduced, or
15 terminated. The term adverse determination shall not include any
16 decision to deny, reduce, or terminate services that are not covered
17 for reasons other than medical necessity or the nature of the
18 service;

19 2. "Chronic condition" means a diagnosis of a disease or
20 condition lasting not less than twelve (12) months based on:

21 a. the condition resulting in the need for ongoing
22 intervention with medical products, treatment,
23 services, and special equipment, or
24

1 b. the condition placing limitations on self-care,
2 independent living, and social interactions;

3 3. "Emergency health care services" means health care services
4 provided in a general medical surgical hospital, critical access
5 hospital, or emergency hospital, as such terms are defined in
6 Section 1-701 of Title 63 of the Oklahoma Statutes, that is licensed
7 by the State Department of Health to evaluate and stabilize medical
8 conditions of a recent and onset severity, including severe pain,
9 regardless of the final diagnosis that is given, that would lead a
10 prudent layperson possessing an average knowledge of medicine and
11 health to believe that the individual's condition, sickness, or
12 injury is of such a nature that failure to get immediate medical
13 care could:

- 14 a. place the individual's health in serious jeopardy, or
15 b. result in serious impairment, dysfunction, or
16 disfigurement of a bodily function, bodily organ, or
17 bodily part;

18 4. "Health benefit plan" means a health benefit plan as defined
19 pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

20 5. "Health care provider" or "provider" means a health care
21 provider as defined pursuant to Section 6571 of Title 36 of the
22 Oklahoma Statutes;

1 6. "Health care service" or "health care services" means health
2 care services as defined pursuant to Section 1219.6 of Title 36 of
3 the Oklahoma Statutes;

4 7. "Medications for opioid use disorder" or "MOUD" means the
5 use of medications, commonly in combination with counseling and
6 behavioral therapies, to treat opioid use disorder. MOUD shall
7 include medications approved by the United States Food and Drug
8 Administration for use to treat opioid addiction including
9 methadone, buprenorphine administered alone or in combination with
10 naloxone, and extended-release injectable naltrexone;

11 8. "National Council for Prescription Drug Programs SCRIPT
12 Standard Version" or "NCPDP SCRIPT Standard" means the National
13 Council for Prescription Drug Programs SCRIPT Standard Version
14 2017071 or any subsequently released version, or the most recent
15 standard adopted by the United States Department of Health and Human
16 Services;

17 9. "Prior authorization" means the utilization review process
18 that occurs following a request from a health care provider for
19 determining medical necessity of an otherwise covered health care
20 service, as required by the health benefit plan;

21 10. "Urgent health care service" means a health care service
22 that, if the application of a time period for a non-expedited prior
23 authorization request were applied, in the opinion of the requesting
24 physician, could:

- 1 a. seriously jeopardize the life or health of the
2 enrollee or the ability of the enrollee to regain
3 maximum function, or
4 b. subject the enrollee to severe pain that cannot be
5 adequately managed without the care or treatment that
6 is the subject of the utilization review;

7 11. "Utilization review" means utilization review as defined
8 pursuant to Section 6475.3 of Title 36 of the Oklahoma Statutes; and

9 12. "Utilization review entity" means an individual or entity
10 that conducts the prior authorization process on behalf of a health
11 benefit plan.

12 SECTION 3. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 6476.3 of Title 36, unless there
14 is created a duplication in numbering, reads as follows:

15 A. Any utilization review entity used by a health benefit plan
16 shall make current prior authorization requirements and restrictions
17 readily accessible on its website to enrollees, health care
18 providers, and the general public. Requirements and restrictions
19 shall be described in detail and in written, easily understandable
20 language.

21 B. If a utilization review entity intends to implement or amend
22 the prior authorization requirements or restrictions of the health
23 benefit plan, the utilization review entity shall provide written
24 notice to health care providers of the new or amended requirement or

1 restriction not less than sixty (60) days before the requirement or
2 restriction is implemented. Prior to implementation, the entity
3 shall ensure that the new or amended requirement or restriction is
4 reflected on the websites of the entity and the health benefit plan.

5 C. A utilization review entity making determinations on behalf
6 of a health benefit plan shall make statistics regarding prior
7 authorization approvals and denials available and readily accessible
8 on its website to enrollees, health care providers, and the general
9 public. Entities shall include the following information regarding
10 approved or denied prior authorization requests:

- 11 1. Physician specialty;
- 12 2. Medication or diagnostic test or procedure;
- 13 3. Determination of the prior authorization request;
- 14 4. Reason for denial;
- 15 5. If an adverse determination has been appealed;
- 16 6. If an appeal of an adverse determination is approved or
17 denied; and
- 18 7. The length of time between submission to and responses from
19 a utilization review entity.

20 SECTION 4. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 6476.4 of Title 36, unless there
22 is created a duplication in numbering, reads as follows:

23 A. Prior to issuance of an adverse determination on a prior
24 authorization request, the utilization review entity shall provide

1 the opportunity to the requesting physician to discuss the medical
2 necessity of the health care service verbally by telephone or
3 electronic means.

4 B. A physician shall make any adverse determination to be
5 issued by a utilization review entity. The physician shall:

6 1. Possess a current and valid nonrestricted license to
7 practice medicine in this state;

8 2. Be of the same specialty as a health care provider who would
9 typically provide the health care service involved in the request;
10 and

11 3. Have experience treating patients with the medical condition
12 or disease for which the health care service is being requested.

13 C. A physician making an adverse determination under subsection
14 B of this section shall make the determination under the clinical
15 direction of a medical director of the utilization review entity or
16 health benefit plan who is responsible for the provision of health
17 care services provided to enrollees in this state.

18 D. Any appeal of an adverse determination issued by a
19 utilization review entity shall be conducted by an independent
20 review organization set forth in the Uniform Health Carrier External
21 Review Act.

22 SECTION 5. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 6476.5 of Title 36, unless there
24 is created a duplication in numbering, reads as follows:

1 A. Except as otherwise provided for in this section, if a
2 utilization review entity requires an approved prior authorization
3 request of a health care service, the utilization review entity
4 shall make a determination on the request and notify the enrollee
5 and the enrollee's health care provider within forty-eight (48)
6 hours of obtaining all necessary information to make such
7 determination.

8 B. 1. Utilization review of emergency health care services
9 shall comply with the federal No Surprises Act, Pub. L. 116-260.

10 2. A utilization review entity shall not require an approved
11 prior authorization request for pre-hospital transportation or prior
12 to the provision of emergency health care services.

13 3. A utilization review entity shall allow an enrollee and the
14 enrollee's health care provider a minimum of twenty-four (24) hours
15 following an emergency admission or rendering emergency health care
16 services for the enrollee or health care provider to notify the
17 utilization review entity of the admission or rendering of emergency
18 health care services. If the admission or emergency health care
19 service occurs on a holiday or weekend, a utilization review entity
20 shall not require notification until the next business day after the
21 admission or rendering of the emergency health care services.

22 4. A health benefit plan shall cover, and a utilization review
23 entity shall approve, a prior authorization request for emergency
24 health care services necessary to screen and stabilize an enrollee.

1 If a health care provider certifies in writing to a utilization
2 review entity within seventy-two (72) hours of an enrollee's
3 admission that the enrollee's condition required emergency health
4 care services, such certification shall establish a presumption that
5 the emergency health care services were medically necessary and such
6 presumption may be rebutted only if the utilization review entity
7 can establish, with clear and convincing evidence, that the
8 emergency health care services were not medically necessary.

9 5. If an enrollee of a health benefit plan receives an
10 emergency health care service that requires immediate post-
11 evaluation or post-stabilization services, a utilization review
12 entity shall make a prior authorization determination within sixty
13 (60) minutes of receiving a request. If a determination is not made
14 within the time frame provided in this paragraph, the authorization
15 request shall be deemed approved.

16 C. No utilization review entity may require a prior
17 authorization request for the provision of MOUD.

18 D. A utilization review entity shall issue a determination on a
19 prior authorization request concerning urgent care services and
20 notify the enrollee and the requesting health care provider of the
21 determination not less than twenty-four (24) hours after receiving
22 all necessary information to complete the prior authorization review
23 for the requested health care services.

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1 E. For the purposes of this section, "necessary information"
2 shall include but not be limited to the results of any face-to-face
3 clinical evaluations or second opinions.

4 SECTION 6. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 6476.6 of Title 36, unless there
6 is created a duplication in numbering, reads as follows:

7 A. No utilization review entity may revoke, limit, condition,
8 or restrict an approved prior authorization request if care is
9 provided within forty-five (45) business days from the date the
10 health care provider received approval for the prior authorization.

11 B. A utilization review entity shall not deny or reduce payment
12 for a health care service exempted from a prior authorization
13 requirement pursuant to this act, including a health care service
14 performed or supervised by another health care provider when the
15 health care provider who ordered the service received the prior
16 authorization exemption, unless the rendering provider:

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

21 2. The health care service was not a covered service on the
22 date that the service was provided to the enrollee;

23 3. The provider was no longer contracted with the health
24 benefit plan on the date that the care was provided;

1 4. The provider failed to meet the timely filing requirements
2 of the utilization review entity;

3 5. The utilization review entity does not have liability for a
4 claim; or

5 6. The patient was no longer eligible for health care coverage
6 on the date that care was provided.

7 SECTION 7. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6476.7 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. Except as provided for in subsection B of this section, an
11 approved prior authorization request shall be valid for one (1) year
12 from the date that the health care provider receives an approved
13 prior authorization determination. For prior authorization requests
14 approved regarding prescription drugs prescribed to an enrollee, the
15 approved request shall be effective regardless of any changes in
16 dosage.

17 B. If a utilization review entity approves a prior
18 authorization request for the treatment of a chronic or long-term
19 care condition, the prior authorization request shall remain
20 effective and valid for the duration of the treatment and the
21 utilization review entity shall not require the enrollee or provider
22 to obtain a subsequent prior authorization approval for the health
23 care service.

1 SECTION 8. NEW LAW A new section of law to be codified

2 in the Oklahoma Statutes as Section 6476.8 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. On receipt of information documenting a prior authorization
5 request from the enrollee or the enrollee's health care provider, a
6 utilization review entity shall honor a prior authorization request
7 granted to an enrollee or provider from a previous utilization
8 review entity for at least sixty (60) days from the date that an
9 enrollee begins coverage under a new health benefit plan.

10 B. During the time period described in subsection A of this
11 subsection, a utilization review entity may perform its own review
12 to grant a prior authorization.

13 C. If there is a change in coverage of or approval criteria for
14 a health care service, the change in coverage or approval criteria
15 shall not affect an enrollee who received an approved prior
16 authorization request before the effective date of the change for
17 the remainder of the plan year.

18 D. A utilization review entity shall continue to honor an
19 approved prior authorization request when the enrollee changes
20 products or plans within the same health benefit plan.

21 SECTION 9. NEW LAW A new section of law to be codified

22 in the Oklahoma Statutes as Section 6476.9 of Title 36, unless there
23 is created a duplication in numbering, reads as follows:

1 No later than January 1, 2025, any health benefit plan offering
2 pharmacy benefits shall accept and respond to prior authorization
3 requests regarding pharmacy benefits through a secure electronic
4 transmission pursuant to standards for transaction under the NCPDP
5 SCRIPT Standard. Facsimile, propriety payer portals, electronic
6 forms, or any other technology not directly integrated with a
7 physician's electronic health record or electronic prescribing
8 system shall not be considered secure electronic transmission.

9 SECTION 10. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6476.10 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 Any failure by a utilization review entity to comply with the
13 provisions of this act shall result in any pending prior
14 authorization requests to be automatically deemed approved by the
15 utilization review entity.

16 SECTION 11. This act shall become effective November 1, 2024.

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