

1                   **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2                                   STATE OF OKLAHOMA

3                                   2nd Session of the 59th Legislature (2024)

4 HOUSE BILL 3862

                                  By: Ford

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7                                   AS INTRODUCED

8                   An Act relating to health insurance; defining terms;  
9                   providing for disclosure and review of prior  
10                  authorization requirements; providing who shall make  
11                  adverse determinations; providing for personnel  
12                  qualifications; requiring consultations prior to  
13                  adverse determinations; providing requirements for  
14                  certain physicians; providing for retrospective  
15                  denial; providing for exemptions; providing for  
16                  failure to comply; providing for codification; and  
17                  providing an effective date.

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

19                  SECTION 1.           NEW LAW           A new section of law to be codified  
20                  in the Oklahoma Statutes as Section 6570.1 of Title 36, unless there  
21                  is created a duplication in numbering, reads as follows:

22                  As used in this section:

23                  1. "Prior authorization" means the process by which utilization  
24                  review entities determine the medical necessity and/or medical  
                  appropriateness of otherwise covered health care services prior to  
                  the rendering of such health care services. Prior authorization

1 also includes any health insurer's or utilization review entity's  
2 requirement that an enrollee or health care provider notify the  
3 health insurer or utilization review entity prior to providing a  
4 health care service; and

5 2. "Utilization review entity" means an individual or entity  
6 that performs prior authorization for an:

- 7 a. insurer that writes health insurance policies, and
- 8 b. a preferred provider organization, health maintenance  
9 organization, or exclusive provider organization.

10 SECTION 2. NEW LAW A new section of law to be codified  
11 in the Oklahoma Statutes as Section 6570.2 of Title 36, unless there  
12 is created a duplication in numbering, reads as follows:

13 A. A utilization review entity shall make any current prior  
14 authorization requirements and restrictions readily accessible on  
15 its website to enrollees, health care professionals, and the general  
16 public. This includes the written clinical criteria. Requirements  
17 shall be described in detail but also in easily understandable  
18 language.

19 B. If a utilization review entity intends either to implement a  
20 new prior authorization requirement or restriction or amend an  
21 existing requirement or restriction, the utilization review entity  
22 shall ensure that the new or amended requirement is not implemented  
23 unless the utilization review entity's website has been updated to  
24 reflect the new or amended requirement or restriction.

1 C. If a utilization review entity intends either to implement a  
2 new prior authorization requirement or restriction or amend an  
3 existing requirement or restriction, the utilization review entity  
4 shall provide health care providers of enrollees written notice of  
5 the new or amended requirement or amendment no less than sixty (60)  
6 days before the requirement or restriction is implemented.

7 SECTION 3. NEW LAW A new section of law to be codified  
8 in the Oklahoma Statutes as Section 6570.3 of Title 36, unless there  
9 is created a duplication in numbering, reads as follows:

10 A. A utilization review entity must ensure that all adverse  
11 determinations are made by a physician.

12 1. The physician must:

- 13 a. possess a current and valid non-restricted license to  
14 practice medicine in the state of Oklahoma,
- 15 b. be of the same specialty as the physician who  
16 typically manages the medical condition or disease or  
17 provides the health care service involved in the  
18 request,
- 19 c. have experience treating patients with the medical  
20 condition or disease for which the health care service  
21 is being requested, and
- 22 d. make the adverse determination under the clinical  
23 direction of one of the utilization review entity's  
24 medical directors who is responsible for the provision

1 of health care services provided to enrollees of  
2 Oklahoma.

3 SECTION 4. NEW LAW A new section of law to be codified  
4 in the Oklahoma Statutes as Section 6570.4 of Title 36, unless there  
5 is created a duplication in numbering, reads as follows:

6 If a utilization review entity is questioning the medical  
7 necessity of a health care service, the utilization review entity  
8 must notify the enrollee's physician that medical necessity is being  
9 questioned. Prior to issuing an adverse determination, the  
10 enrollee's physician must have the opportunity to discuss the  
11 medical necessity of the health care service on the telephone with  
12 the physician who will be responsible for determining authorization  
13 of the health care service under review.

14 SECTION 5. NEW LAW A new section of law to be codified  
15 in the Oklahoma Statutes as Section 6570.5 of Title 36, unless there  
16 is created a duplication in numbering, reads as follows:

17 A. A utilization review entity must ensure that all appeals are  
18 reviewed by a physician.

19 1. The physician must:

- 20 a. possess a current and valid non-restricted license to  
21 practice medicine in Oklahoma,
- 22 b. be currently in active practice in the same or similar  
23 specialty as a physician who typically manages the  
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1 medical condition or disease for at least five (5)  
2 consecutive years,

3 c. be knowledgeable of, and have experience providing,  
4 the health care services under appeal,

5 d. not be employed by a utilization review entity or be  
6 under contract with the utilization review entity  
7 other than to participate in one or more of the  
8 utilization review entity's health care provider  
9 networks or to perform reviews of appeals, or  
10 otherwise have any financial interest in the outcome  
11 of the appeal,

12 e. not have been directly involved in making the adverse  
13 determination, and

14 f. consider all known clinical aspects of the health  
15 care, service under review, including, but not limited  
16 to, a review of all pertinent medical records provided  
17 to the utilization review entity by the enrollee's  
18 health care provider, any relevant records provided to  
19 the utilization review entity by a health care  
20 facility, and any medical literature provided to the  
21 utilization review entity by the health care provider.

22 SECTION 6. NEW LAW A new section of law to be codified  
23 in the Oklahoma Statutes as Section 6570.6 of Title 36, unless there  
24 is created a duplication in numbering, reads as follows:

1       A. A utilization review entity may not revoke, limit, condition  
2 or restrict a prior authorization if care is provided within forty-  
3 five (45) business days from the date the health care provider  
4 received the prior authorization.

5       B. In the case of preventive care that has prior authorization  
6 approval, if it has been determined medically necessary by the  
7 medical provider that additional preventive care is needed, it shall  
8 be covered under the initial pre-authorization. For any  
9 subsequently provided preventive care covered by the initial pre-  
10 authorization, it must be in connection to care furnished by the  
11 medical provider. Any care provided to an enrollee that is not in  
12 connection to pre-authorized preventive care shall need to receive  
13 pre-authorization approval.

14       C. Nothing in this section shall be construed to require pre-  
15 authorization approval of care that is already exempted from a pre-  
16 authorization approval.

17       SECTION 7.       NEW LAW       A new section of law to be codified  
18 in the Oklahoma Statutes as Section 6570.7 of Title 36, unless there  
19 is created a duplication in numbering, reads as follows:

20       A. A utilization review entity may not require a health care  
21 provider to complete a prior authorization for a health care service  
22 in order for the enrollee to whom the service is being provided to  
23 receive coverage if in the most recent 12-month period, the  
24 utilization review entity has approved or would have approved not

1 less than eighty percent (80%) of the prior authorization requests  
2 submitted by the health care provider for that health care service.

3 B. A utilization review entity may evaluate whether a health  
4 care provider continues to qualify for exemptions as described in  
5 subsection A not more than once every twelve (12) months. Nothing  
6 in this section requires a utilization review entity to evaluate an  
7 existing exemption or prevents a utilization review entity from  
8 establishing a longer exemption period.

9 C. A health care provider is not required to request an  
10 exemption in order to qualify for an exemption.

11 D. A health care provider who does not receive an exemption may  
12 request from the utilization review entity at any time, but not more  
13 than once per year per service, evidence to support the utilization  
14 review entity's decision. A health care provider may appeal a  
15 utilization review entity's decision to deny an exemption.

16 E. A utilization review entity may only revoke an exemption at  
17 the end of the 12-month period if the utilization review entity:

18 1. Makes a determination that the health care provider would  
19 not have met the eighty percent (80%) approval criteria based on a  
20 retrospective review of the claims for the particular service for  
21 which the exemption applies for the previous three (3) months, or  
22 for a longer period if needed to reach a minimum of ten (10) claims  
23 for review;

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1           2. Provides the health care provider with the information it  
2 relied upon in making its determination to revoke the exemption; and

3           3. Provides the health care provider a plain language  
4 explanation of how to appeal the decision.

5           F. An exemption remains in effect until the 30th day after the  
6 date the utilization review entity notifies the health care provider  
7 of its determination to revoke the exemption, or if the health care  
8 provider appeals the determination, the fifth day after the  
9 revocation is upheld on appeal.

10          G. A determination to revoke or deny an exemption must be made  
11 by a health care provider licensed in Oklahoma of the same or  
12 similar specialty as the health care provider being considered for  
13 an exemption and have experience in providing the service for which  
14 the potential exemption applies.

15          H. A utilization review entity must provide a health care  
16 provider that receives an exemption a notice that includes:

17           1. A statement that the health care provider qualifies for an  
18 exemption from pre-authorization requirements;

19           2. A list of services for which the exemptions apply; and

20           3. A statement of the duration of the exemption.

21          I. A utilization review entity shall not deny or reduce payment  
22 for a health care service exempted from a prior authorization  
23 requirement under this section, including a health care service  
24 performed or supervised by another health care provider when the

1 health care provider who ordered such service received a prior  
2 authorization exemption, unless the rendering health care provider:

3 1. Knowingly and materially misrepresented the health care  
4 service in request for payment submitted to the utilization review  
5 entity with the specific intent to deceive and obtain an unlawful  
6 payment from utilization review entity; or

7 2. Failed to substantially perform the health care service.

8 SECTION 8. NEW LAW A new section of law to be codified  
9 in the Oklahoma Statutes as Section 6570.8 of Title 36, unless there  
10 is created a duplication in numbering, reads as follows:

11 Any failure by a utilization review entity to comply with the  
12 deadlines and other requirements specified in this act will result  
13 in any health care services subject to review to be automatically  
14 deemed authorized by the utilization review entity.

15 SECTION 9. This act shall become effective November 1, 2024.

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17 COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/13/2024 - DO  
18 PASS.

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