

STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

HOUSE BILL 4462

By: Newton

AS INTRODUCED

An Act relating to health insurance; providing definitions; establishing that non-urgent care prior authorization requests shall be deemed approved if the utilization review organization fails to take certain action; granting the utilization review organization additional time for decision if network provider is requested to provide additional information; providing requirements for additional information requests; requiring network provider to submit new prior authorization request if they fail to provide all clinical information; requiring network providers to submit non-urgent care requests at least six days before scheduled health care service; establishing that urgent care prior authorization requests shall be deemed approved if the utilization review organization fails to take certain action; requiring network provider to submit additional information within twenty four hours of receiving request; directing utilization review organizations to ensure requests for prior authorization are made by physician or other competent health care professional; requiring utilization review organizations to include certain information with notice of adverse determination; requiring utilization review organizations to ensure adverse determinations are made by qualified physicians; directing utilization review organizations to make appeals process readily accessible on website; requiring response to appeals within certain timeframe; requiring appeals to be decided by physician other than physician who made original adverse determination; directing insurers to exempt certain network providers from obtaining prior authorization for covered health care services; clarifying that exemption shall be effective for

1 succeeding year upon determination by utilization
2 review organization; permitting insurers to rescind
3 exemption for certain actions by health care
4 professional; permitting insurers to automatically
5 renew exemption if certain conditions are met;
6 directing insurers to make written notice of a
7 decision granting or declining renewal of an
8 exemption; providing required contents for notice of
9 rescission or declination of exemption; requiring
10 insurer afford a health care professional reasonable
11 opportunity to challenge grounds for a decision;
12 directing for reconsideration to be performed by
13 qualified physician; clarifying decision on
14 reconsideration is final; requiring information be
15 held in strictest confidence; clarifying health care
16 professional whose exemption was rescinded or not
17 renewed for certain reasons remains automatically
18 eligible for an exemption; establishing that these
19 exemptions do not apply to experimental health care
20 services; granting the Oklahoma Insurance
21 Commissioner rule making authority; providing for
22 codification; and providing an effective date.

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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 6567.1 of Title 36, unless there
is created a duplication in numbering, reads as follows:

As used in this act:

1. "Additional business day" means the first weekday not
designated as a state or federal holiday;

2. "Adverse determination" means a determination by a
utilization review organization that a request for coverage of a
benefit under a health benefit plan does not meet the insurer's
policies or guidelines for medical necessity or appropriateness,

1 including treatment setting, level of care, or effectiveness. The
2 term includes a denial, reduction, termination, or modification of
3 the benefit requested or payment therefor;

4 3. "Artificial intelligence" means a machine-based system that
5 may include software or physical hardware that performs tasks, based
6 upon data set inputs, which requires human-like perception,
7 cognition, planning, learning, communication, or physical action and
8 which is capable of improving performance based upon learned
9 experience without significant human oversight toward influencing
10 real or virtual environments;

11 4. "Enrollee" means an individual who contracts for,
12 subscribes, or participates as a dependent under a health benefit
13 plan;

14 5. "Health benefit plan" means:

- 15 a. any plan, policy, or contract issued, delivered, or
16 renewed in this state that provides medical benefits
17 that include payment or reimbursement for
18 hospitalization, physician care, treatment, surgery,
19 therapy, drugs, equipment, and other medical expenses,
20 regardless of whether the plan is for a group or an
21 individual, and
22 b. the term does not include accident-only, specified
23 disease, individual hospital indemnity, credit,
24 dental-only, Medicare supplement, long-term care,

1 disability income, or other limited benefit health
2 insurance policies, or coverage issued as supplemental
3 to liability insurance, workers' compensation, or
4 automobile medical payment insurance;

5 6. "Health care professional" means a physician or other health
6 care provider who is licensed by an occupational licensing board
7 under Title 59 or Title 63 of the Oklahoma Statutes.

8 7. "Health care service" means diagnosing, testing, monitoring,
9 or treating a human disease, disorder, syndrome, or illness that may
10 include, but not be limited to, hospitalization, physician care,
11 treatment, surgery, therapy, drugs, or medical equipment;

12 8. "Insurer" means any entity that issues, delivers, or renews
13 a health benefit plan, a health maintenance organization, or a
14 nonprofit health care service;

15 9. "Medical necessity" means the question of whether a health
16 care service is medically necessary;

17 10. "Network providers" means facilities and health care
18 professionals who, pursuant to a contract with the insurer, have
19 agreed to provide health care services to enrollees with an
20 expectation of receiving payment, other than copayments,
21 coinsurance, or deductibles, directly or indirectly, from the
22 insurer;

23 11. "Prior authorization" means a written or oral
24 determination made by a utilization review organization that a

1 health care service is a benefit covered under the applicable health
2 benefit plan which, under the enrollee's clinical circumstances, is
3 medically necessary or satisfies another requirement imposed by the
4 insurer or utilization review organization, and thus satisfies the
5 requirements for payment or reimbursement;

6 12. "Urgent care request" means a request for prior
7 authorization of a health care service for which the time period for
8 making a nonurgent determination of prior authorization could result
9 in at least one of the following outcomes for the enrollee:

- 10 a. death,
- 11 b. permanent impairment of health,
- 12 c. inability to regain maximum bodily function, or
- 13 d. severe pain that cannot be adequately managed; and

14 13. "Utilization review organization" means the entity that
15 makes determinations of prior authorization, which may be the
16 insurer or other entity that is a designated contractor or agent of
17 the insurer.

18 SECTION 2. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 6567.2 of Title 36, unless there
20 is created a duplication in numbering, reads as follows:

21 A. A prior authorization request that has not been submitted as
22 an urgent care request is deemed approved if, within seventy-two
23 (72) hours plus, if applicable, one (1) additional business day,

1 after the date and time of submission of the request, the
2 utilization review organization fails to do one of the following:

3 1. Approve, deny, or fail in any way to acknowledge the
4 request;

5 2. Request from the network provider all additional
6 information needed to make a determination; or

7 3. Except for a prior authorization request for a prescription
8 drug, fails to notify the network provider that a determination of
9 prior authorization is delayed because the question of medical
10 necessity is difficult to resolve.

11 B. 1. If a network provider is requested to provide additional
12 information, whether in the form of additional documentation or in
13 the circumstances described in paragraph 2 of this subsection, the
14 utilization review organization shall have an additional seventy-two
15 (72) hours plus, if applicable, one (1) additional business day,
16 after the date and time of submission of the additional information
17 in which to make its decision or the prior authorization request is
18 deemed approved; and

19 2. A request for additional information under paragraph 1 of
20 this subsection shall include, in the case of a question of medical
21 necessity which is difficult to resolve, all of the following:

22 a. a direct phone number to the utilization review
23 organization,
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1 b. hours of availability of the utilization review
2 organization's physician or other health care
3 professional who has authority to make the prior
4 authorization determination, and

5 c. a statement that there is an opportunity to discuss
6 the medical necessity of the health care service
7 directly with the physician or other health care
8 professional who has authority to make the prior
9 authorization determination.

10 C. Failure by the network provider to submit all clinical
11 information, including its response to a request for additional
12 information, within six (6) calendar days after the date of the
13 initial submission of the request shall necessitate the network
14 provider to request a new prior authorization.

15 D. A network provider shall submit a request for a prior
16 authorization that is not an urgent care request at least six (6)
17 calendar days before the scheduled health care service.

18 SECTION 3. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 6567.3 of Title 36, unless there
20 is created a duplication in numbering, reads as follows:

21 A. A prior authorization request that is submitted as an urgent
22 care request is deemed approved if, within twenty-four (24) hours
23 after the date and time of submission of the request, the
24 utilization review organization fails to do one of the following:

1 1. Approve or deny the request; or

2 2. Request from the network provider all additional information
3 needed to make a determination.

4 B. 1. A network provider shall submit additional information
5 requested by the utilization review organization within twenty-four
6 (24) hours of receiving a request for additional information; and

7 2. The prior authorization request is deemed approved by the
8 utilization review organization if it fails to grant or deny the
9 request or otherwise respond to the submission of additional
10 information by the network provider within twenty-four (24) hours
11 after the date and time of submission of the requested additional
12 information.

13 C. Failure by the network provider to submit all clinical
14 information in response to a request for additional information by
15 the utilization review organization within twenty-four (24) hours
16 after the date and time of the request shall necessitate the network
17 provider to request a new prior authorization.

18 SECTION 4. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 6567.4 of Title 36, unless there
20 is created a duplication in numbering, reads as follows:

21 A utilization review organization shall ensure that all
22 determinations on requests for prior authorization are made by a
23 physician or other health care professional who is competent to
24 evaluate and reject, if appropriate, any recommendation or

1 conclusion of artificial intelligence, based upon all relevant
2 factors that include, but are not limited to, the enrollee's
3 clinical circumstances, the information submitted by the network
4 provider, and all applicable criteria, policies, and guidelines.

5 SECTION 5. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 6567.5 of Title 36, unless there
7 is created a duplication in numbering, reads as follows:

8 A. When a utilization review organization issues an adverse
9 determination in response to a request for prior authorization, it
10 shall send a notification of its determination to both the network
11 provider and enrollee, which shall include all of the following
12 information:

13 1. The reasons for the adverse determination and, if
14 applicable, relevant evidence-based criteria, including a
15 description of missing or insufficient documentation, or lack of
16 coverage under the health benefit plan;

17 2. Instructions on how to appeal the determination; and

18 3. Additional documentation or other information necessary to
19 support the appeal.

20 B. In addition to the requirement of Section 4 of this act, a
21 utilization review organization shall ensure that all adverse
22 determinations are made by a physician who meets all of the
23 following requirements:

1 1. Possesses a current, nonrestricted license to practice
2 medicine issued by an occupational licensure board in any state or
3 territory of the United States;

4 2. Is board-eligible for certification or has equivalent
5 clinical practice experience in the same specialty as the physician
6 or other health care professional who would typically provide the
7 health care service for which prior authorization is requested;

8 3. Makes determinations under the supervision of a medical
9 director who is a current, licensed physician in the State of
10 Oklahoma; and

11 4. Receives compensation or payment from the utilization
12 review organization which is in no way increased or enhanced by
13 making an adverse determination.

14 SECTION 6. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 6567.6 of Title 36, unless there
16 is created a duplication in numbering, reads as follows:

17 A. A utilization review organization shall make its process for
18 appealing an adverse determination on a request for prior
19 authorization readily accessible on its website to its network
20 providers and enrollees.

21 B. When an appeal is received from a network provider or
22 enrollee on an adverse determination on a request for prior
23 authorization, a utilization review organization shall send a
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notification to both the network provider and enrollee confirming, reversing, or modifying the adverse determination within:

1. Seventy-two (72) hours plus, if applicable, one (1) additional business day, for a nonurgent request; or

2. Twenty-four (24) hours for an urgent request.

C. A utilization review organization shall ensure that all appeals from adverse determinations are decided by a physician other than the physician who made the adverse determination and who meets the requirements of paragraphs 1 through 4 of subsection B of Section 5 of this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning January 1, 2027, an insurer shall exempt a health care professional who is a network provider from obtaining prior authorization for a health care service covered under a health benefit plan when all of the following requirements are met:

1. The health care service is otherwise subject to a prior authorization requirement as a precondition to approval for payment or reimbursement;

2. The health care professional provided the health care service to at least seven different patients during the year 2025; and

1 3. Prior authorization was approved, based upon the medical
2 necessity criteria used by the utilization review organization, for
3 ninety percent (90%) or more of the requests made by the health care
4 professional for the health care service.

5 B. The exemption provided in this section shall be effective
6 for the succeeding year upon determination by the utilization review
7 organization.

8 C. 1. Notwithstanding subsection B of this section, an insurer
9 may rescind the exemption at any time if the health care
10 professional knowingly and materially misrepresents the health care
11 service, including a substantial failure to provide the health care
12 service, in a claim made with the specific intent to deceive the
13 insurer and obtain an unlawful payment or reimbursement;

14 2. Notwithstanding subsection B of this section, an insurer may
15 rescind the exemption no less than ninety (90) days after the
16 exemption takes effect if the insurer or utilization review
17 organization detects an increase in claims for payment or
18 reimbursement for the health care service for which the exemption is
19 granted that is disproportionate or anomalous to the health care
20 professional's historic rate of providing the health care service;
21 and

22 3. An insurer shall give written notice to a health care
23 professional that the exemption is being rescinded no less than
24 twenty (20) days in advance of the effective date of the rescission.

1 D. 1. An insurer may automatically renew an exemption from
2 prior authorization for a health care service for a succeeding year
3 if the health care professional submits fewer than seven (7) claims
4 for payment or reimbursement for the health care service during the
5 current exemption year, or for any other reason in the insurer's
6 discretion;

7 2. a. an insurer may retrospectively review the health care
8 professional's provision of the health care service
9 during the exemption year, using a review period of at
10 least nine (9) months, as a condition for renewing the
11 exemption for the succeeding year,

12 b. pursuant to a retrospective review, an insurer may
13 decline to renew the exemption on any of the following
14 grounds:

- 15 (1) the review discloses that less than ninety
16 percent (90%) of the claims paid or reimbursed
17 would meet the medical necessity criteria used by
18 the utilization review organization, or
19 (2) the review discloses a claim or a pattern that
20 would be grounds for rescission of the exemption
21 as described in subsection c of this section; and

22 3. An insurer shall make efforts to ensure that written notice
23 of a decision granting or declining renewal of an exemption is
24 provided to a health care professional who has a current exemption

1 no later than at least thirty (30) days before the one-year
2 exemption period expires.

3 E. 1. When an insurer rescinds or declines to renew an
4 exemption from prior authorization for a health care service, it
5 shall send written notice of its decision to the health care
6 professional, which shall include:

7 a. the reason for the decision, and

8 b. instructions on how to submit a request for
9 reconsideration of the decision;

10 2. A health care professional may submit a request for
11 reconsideration of a decision to rescind or decline renewal of an
12 exemption within twenty (20) days of receiving notice of the health
13 insurer's decision;

14 3. a. an insurer shall afford a health care professional a
15 reasonable opportunity, including by a meeting or
16 informal hearing conducted in person or
17 electronically, to challenge the grounds for a
18 decision to rescind or decline renewal of an
19 exemption, to include the presentation of any relevant
20 documentation such as clinical records or claims data
21 as may be relevant to the reason for the insurer's
22 decision, and

23 b. reconsideration of a decision to decline renewal which
24 involves the issue of medical necessity shall be

1 performed on behalf of the insurer by a physician who
2 meets the requirements of subsection B of Section 5 of
3 this act;

4 4. A decision by a health insurer on reconsideration, affirming
5 or denying its rescission or nonrenewal, is final;

6 5. All information, including, but not limited to, oral or
7 written communications, clinical records, supporting documentation,
8 up to the reason for rescinding or declining to renew an exemption,
9 or any decision on a request for reconsideration, shall be held in
10 the strictest confidence by both the insurer and the health care
11 professional, subject to any of the following:

- 12 a. reporting by an insurer of the facts of a case
13 described in paragraph 1 of subsection C of this
14 section to the commissioner, an occupational licensing
15 board, or law enforcement,
- 16 b. disclosure to a third party by mutual, written
17 agreement of the insurer and the health care
18 professional, subject to the federal Health Insurance
19 Portability and Accountability Act (HIPAA), 42 U.S.C.
20 Section 1320d et seq., or
- 21 c. use by the insurer or health care provider as
22 necessary to invoke or enforce any provision under a
23 network provider contract.

24 F. A health care professional who has been granted an

1 exemption from prior authorization for a health care service
2 which has been rescinded or not renewed, and who is otherwise
3 a network provider, remains automatically eligible to receive
4 an exemption for a subsequent year for any health care service
5 he or she provides which may qualify for exemption, unless an
6 exemption was rescinded in a case described in paragraph 1 of
7 subsection C of this section.

8 G. An exemption from prior authorization under this section
9 shall not apply to any health care service that is deemed by the
10 health care insurer to be experimental.

11 SECTION 8. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 6567.8 of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

14 The Oklahoma Insurance Commissioner may adopt any rules
15 necessary to implement and enforce this act.

16 SECTION 9. This act shall become effective November 1, 2026.
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18 60-2-14146 MJ 01/06/26
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