STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 1826

By: Boyd and Roach of the House

and

Fisher of the Senate

COMMITTEE SUBSTITUTE

[public health and safety - managed health care - Oklahoma Managed Care External Review Act - internal reviews - codification –

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 2528.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Managed Care External Review Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Managed Care External Review Act:

1. "Designee of an insured person" means an individual designated through expressed written consent by an insured person to represent the interests of the insured person, including the insured person's physician or where applicable such person's primary care physician;

2. "External review" means a review of a decision by a health benefit plan to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit by an independent review organization upon the request of an insured

person or the designee of an insured person, and the organization's subsequent decision to uphold or reverse the denial of such coverage or reimbursement made by the health benefit plan;

3. "Health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization, a preferred provider plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA), or a self-insured plan;

4. "Independent review organization" means an entity certified by the State Department of Health to conduct external reviews;

5. "Insured person" means an individual who receives medical care and treatment through a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of such person; and

6. "Internal review" means procedures established by a health benefit plan, pursuant to the provisions of Section 4 of this act, for an internal reevaluation of an initial decision to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit, and the subsequent decision by the health benefit plan to grant or deny such coverage or reimbursement.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

An insured person or the parent, guardian, or designee of the insured person shall have the right to an external review by an independent review organization of a decision under a health benefit plan to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit when:

1. All applicable internal appeals procedures established by the health benefit plan have been exhausted;

2. The denial is based on a determination by the health benefit plan that the service or treatment is not medically necessary, medically appropriate, or medically effective;

3. The usual, customary and reasonable charge or allowable charge, as shown in the health benefit plan's fee schedule, of the service or treatment for which coverage or reimbursement was denied by the health benefit plan exceeds One Thousand Dollars ($1,000.00); and

4. The insured person or the designee of the insured person agrees to the terms and conditions of external review as provided in Section 5 of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

Except as specifically provided by this section, every health benefit plan that is offered, issued or renewed after February 1, 2000, shall provide for an external review process by an independent review organization in accordance with the provisions of the Oklahoma Managed Care External Review Act. The following shall not be subject to the provisions of the Oklahoma Managed Care External Review Act:

1. Health benefit plans that do not use a primary care physician-based prior authorization system and that have written procedures that permit external review;

2. Health benefit plans and health care provided pursuant to Titles XVIII, XIX or XXI or the federal Social Security Act; and

3. Workers' compensation benefits or coverage subject to the provisions of Title 85 of the Oklahoma Statutes.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. An insured person or the designee of an insured person shall be required to pay Twenty-five Dollars ($25.00) toward the cost of an external review.

1. Such payment shall be due at the time the preliminary screening is completed and the insured person or the designee of the insured person is notified of a decision by the independent review organization to accept the appeal, pursuant to procedures specified in this act, for a full external review.

2. Whenever the insured person or the designee of the insured person prevails, at the completion of the external review, the payment shall be refunded.

3. The health benefit plan shall be responsible for the remaining costs related to the external review process.

B. The decision of the independent review organization is binding on the health benefit plan, the insured person, and the health care provider for the insured person. A condition of completing the external review process shall be an agreement by the parties to waive the right to file a court action to resolve the issue in dispute, either during or at the completion of the external review process.

C. The number of appeals for an external review by an insured person or a designee of the insured person shall be limited to one appeal per authorization decision.

D. The health benefit plan may, at its discretion, determine that additional information provided by the insured person or the designee or physician of the insured person justifies a reconsideration of the decision to deny coverage or reimbursement. Upon notice to the insured person or the designee of the insured person and the independent review organization, a subsequent

decision by the health benefit plan to grant coverage or reimbursement based upon such reconsideration shall terminate the external review.

E. Nothing in the Oklahoma Managed Care External Review Act shall be construed to:

1. Create any new private right or cause of action for or on behalf of any covered person; or

2. Render the health benefit plan liable for damages arising from any act or omission of the independent review organization.

F. Independent review organizations and expert reviewers assigned by an independent review organization to conduct an external review shall not be liable for damages arising from decisions made pursuant to the Oklahoma Managed Care External Review Act. This provision shall not apply to an act or omission by such entities that is made in bad faith or that involves gross negligence.

G. After an appeal has been accepted for external review by an independent review organization, an informed consent form, signed by the insured person or the designee of the insured person acknowledging receipt of a copy of the terms and conditions of the external review process as provided by this section and acknowledging understanding of and consent to such terms and conditions, shall be required prior to initiating a full external review.

H. A health benefit plan shall not remove a physician from its plan, refuse to renew a physician with the plan, or otherwise discipline a physician for advocating on behalf of an insured person in either an internal or external review.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. An appeal of a decision by a health benefit plan to deny coverage or reimbursement for a service or treatment, except as provided in Section 7 of this act, and a request for an external review shall be initiated in writing by the insured person or the designee of the insured person. The request shall be delivered to the health benefit plan within thirty (30) days after receipt of written notification of the denial from the health benefit plan following completion of the internal review process.

B. Upon receipt of the request for an external review, the health benefit plan shall immediately select and notify an independent review organization from a list of independent review organizations certified by the State Department of Health, and inform the insured person or the designee of the insured person of the name and location of the independent review organization selected; provided, however, the insured person or the designee of the insured person may object to the selection for cause and shall make such objection known to the Department. The Department may require the health benefit plan to select a different independent review organization from the list and to notify the insured person or the designee of the insured person of the name and location of the newly selected independent review organization.

C. Within five (5) business days of such selection and notification, the insured person or the designee of the insured person shall provide the independent review organization with the following documents:

1. A written request for an external review of the decision by the health benefit plan to deny coverage or reimbursement and a statement of the reasons for the request for an external review;

2. A copy of the final decision to deny coverage or reimbursement made by the health benefit plan; and

3. A fully executed release authorizing the independent review organization to obtain necessary medical records from the health benefit plan and any relevant health care providers.

D. Upon receipt of a written request for an external review and other documentation required in subsection C of this section, the independent review organization shall conduct a preliminary review of the appeal and shall accept it for a full review when the independent review organization determines that:

1. The individual on whose behalf the appeal is made is or was an insured person or is the designee of an insured person;

2. The service or treatment for which coverage is desired or reimbursement is asked is a covered service or treatment, or a service or treatment provided by contract to the insured person;

3. The insured person or the designee of the insured person has exhausted the internal review procedures of the health benefit plan; and

4. The insured person or the designee of the insured person has notified the health benefit plan of an appeal of the decision and the request for an external review.

E. Upon the completion of the preliminary review, the independent review organization shall immediately make written notification of its decision to accept or deny the appeal for full external review to the insured person or the designee of the insured person, the health benefit plan and, if possible, the physician of the insured person. If an appeal is denied for full external review, a statement of the reasons for such denial shall be included with the notification.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Upon receipt of notification of acceptance of an appeal for full external review from an independent review organization, the

health benefit plan shall provide the independent review organization with the following documents within five (5) business days after receipt of the notification of acceptance of an appeal for full external review:

1. Any information that was submitted to the health benefit plan by the insured person or the designee or physician of the insured person in support of the request for coverage or reimbursement pursuant to the internal review process; and

2. A copy of the contract provisions upon which the denial of coverage or reimbursement was based, any statement by the health benefit plan explaining the reasons for the decision of the health benefit plan not to provide coverage or to deny reimbursement, and any other relevant documents used by the health benefit plan in making its decision.

B. Upon the request of the insured person or the designee of the insured person, the health benefit plan shall provide the information required by subsection A of this section to the insured person or the designee or physician of the insured person; provided, however, the health benefit plan shall not be required to provide any legally privileged information.

C. The independent review organization shall notify the insured person or the designee of the insured person of any additional information it requires within five (5) business days after receipt of the information submitted by the health benefit plan. The insured person or the designee of the insured person shall submit the additional information, or an explanation as to why the additional information cannot be submitted, within five (5) business days of receipt of the request for additional information.

D. The independent review organization shall maintain the confidentiality of medical records submitted to it in accordance with state and federal law, and shall maintain the confidentiality of proprietary information submitted by the health benefit plan.

E. The independent review organization shall issue a written decision on the appeal, stating the reasons why the desired service or treatment or reimbursement for service or treatment should or should not be made by the health benefit plan. Such decision shall be delivered to the insured person or designee of the insured person, the physician of the insured person, and the health benefit plan that is the subject of its decision within thirty (30) days after acceptance of the appeal for external review and receipt of the documentation required by this section.

F. When the physician of the insured person certifies in writing that the time frames established by this section could jeopardize the life or health of the insured person, the decision shall be rendered as rapidly as warranted by the condition of the insured person, but in no event shall such rendering exceed seventy-two (72) hours.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The decision of an independent review organization as to the resolution of an appeal shall be based upon a review of the written record before it. In reaching its decision, the independent review organization shall apply any applicable health benefit plan policy or contract provisions, taking into consideration all pertinent medical records, consulting physician reports, medical and scientific evidence, and other documentation submitted by the parties.

B. Medical and scientific evidence includes, but is not limited to, the following sources:

1. Peer-reviewed scientific studies published by medical journals that meet nationally recognized requirements for scientific manuscripts in that most of the published articles are submitted for review by experts who are not part of the editorial staff;

2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index medicus, excerpta medicus (EMBASE), medline, and Medlars data base of health services technology assessment research (HSTAR);

3. The following standard reference compendia:

a. the American Hospital Formulary Service-Drug Information,

b. the American Medical Association Drug Evaluation,

c. the American Dental Association Accepted Dental Therapeutics, and

d. the United States Pharmacopoeia-Drug Information; and

4. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes for Health, the National Academy of Sciences, the Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.9 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules for the certification of independent review organizations. The rules promulgated by the Board shall:

1. Establish minimum standards that:

a. include procedures for accomplishing informed consent,

b. ensure the independence of the review organization and the review process,

c. ensure the independence of health care professionals providing analyses, recommendations, and other requested information,

d. provide for the confidentiality of medical records,

e. provide for expedited appeals in emergency situations, and

f. ensure fair business practices by independent review organizations.

B. The State Department of Health shall certify, refuse to certify, renew certification or refuse to renew certification of independent review organizations and shall enforce the rules promulgated by the Board.

C. The following organizations shall not be eligible for certification as an independent review organization:

1. Professional trade associations of health care providers or their subsidiaries or affiliates; and

2. Health plans or health plan associations or their subsidiaries or affiliates.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A person assigned by an independent review organization as an expert reviewer shall be a physician and shall:

1. Have expertise in the medical condition of the insured person whose appeal is under review and have knowledge regarding the recommended service or treatment through actual clinical experience;

2. Hold a nonrestricted license in a state of the United States;

3. Be currently certified by an American medical specialty board recognized by the American Osteopathic Association and the American Board of Medical Specialties in the areas appropriate to the subject of review; and

4. Have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity.

B. Neither the expert reviewer nor the independent review organization shall have any material, professional, familial or financial conflict of interest with:

1. The health benefit plan;

2. Any officer, director, or management employee of the health benefit plan;

3. The physician, the physician's medical group, or the independent practice association proposing the service or treatment;

4. The institution at which the service or treatment would be provided;

5. The development or manufacture of the principal drug, device, procedure or other therapy proposed for the insured person whose appeal is under review; or

6. The insured person or designee of the insured person who requested the external review.

C. A potential expert reviewer shall disclose any information regarding a potential conflict of interest to all parties to the review. As used in this section, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to an insured person, except that such exclusion shall not apply to:

1. Academic medical centers that would provide the service or treatment for which coverage is in dispute;

2. Affiliations which are limited to staff privileges at a health facility; or

3. An expert reviewer's participation as a contracting carrier provider where the expert is affiliated with an academic medical center or other similar medical research center that is an independent review entity under this section.

SECTION 11. This act shall become effective February 1, 2000.

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