STATE OF OKLAHOMA

2nd Session of the 48th Legislature (2002)

SENATE BILL 990 By: Rozell

AS INTRODUCED

An Act relating to Insurance; creating the Health Care Consumer Protection and Fraud Prevention Act; providing short title; defining terms; making certain acts related to health care claims, goods and services, payments collections and certain billing practices unlawful; requiring certain out-of-network provider to provide written notice of acceptance of a health plan's fee schedule for certain purpose; requiring written disclosure of possible charges; requiring development of standardized form; requiring written disclosure of ownership interest in certain entity; prohibiting fraudulent billing or billing for services outside specified scope of specialty or license; prohibiting false representation regarding certain denial; requiring notification by a specified provider of certain results in specified time frames; requiring quarterly financial statements and providing for preparation of such reports; requiring signature of specified persons on report; providing for certain additional audit; providing for penalties; stating requirements pursuant to inappropriate placement of a patient account; 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 3650.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Health Care Consumer Protection and Fraud Prevention Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Health Care Consumer Protection and Fraud Prevention Act:

1. “Balance billing” means willfully collecting or attempting to collect an amount from a person, while knowing, or having constructive knowledge, that such collection or attempt violates an agreement, arrangement or contract between the provider and a health care payor;

2. “Commissioner” means the Insurance Commissioner;

3. “Department” means the Insurance Department;

4. “Health plan” means a health maintenance organization or a prepaid health plan as defined in Section 2503 of Title 63 of the Oklahoma Statutes;

5. “Participating provider” means a physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan;

6. “Provider” means a physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies;

7. “Significant abnormal result” means:

a. a diagnostic test result that is twice the value of the normal range typically provided, or

b. any abnormality on a diagnostic test that a physician reviewer has indicated needs further study or advises clinical correlation with the patient’s condition;

8. “Unbundling” means the use of multiple procedure codes when describing individual components of a medical service instead of the use of a single comprehensive procedure code which describes the entire service; and

9. “Upcoding” means the billing for medical services at a higher level of complexity than actually delivered.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. It shall be unlawful for:

1. Any provider to make, present or cause to be made or presented to a health care payor a claim for a health care payment knowing the claim to be false;

2. Any provider to knowingly present to a health care payor a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards; provided, however, any claim submitted by a provider that is considered to represent medically necessary services in accordance with professionally accepted standards shall be paid according to the insured’s benefit plan and claims payment policies and procedures if the provider is a participating provider;

3. Any provider to knowingly make a false statement or false representation of a material fact to a health care payor for use in determining rights to a health care payment. Each claim so made that violates the provisions of this subsection shall constitute a separate violation;

4. Any participating provider to willfully collect or attempt to collect an amount from a person through means including, but not limited to, balance billing, knowing that such collection or attempt violates an agreement, arrangement or contract between the provider and a health care payor; and

5. Any provider to engage in the billing practices of unbundling or upcoding.

B. Any out-of-network provider who determines that a health plan’s fee schedule for the treatment provided will be accepted as

payment in full and so notifies the patient shall do so in writing in order to protect the patient from subsequent balance billing.

C. 1. A provider who is not a participating provider shall disclose to the patient in writing, on a standardized form approved by the Insurance Commissioner, that the patient may be responsible for:

a. higher coinsurance and deductibles,

b. provider charges which exceed the allowable charges of a participating provider for the same services, or

c. all of the provider charges if the member has not followed the health plan's referral and access procedures for the member's health plan.

2. The Insurance Department shall, by rule, develop the standardized form to be used by providers for the disclosures required by this section.

D. When a provider makes a referral to a nonparticipating hospital or ambulatory surgical center, the referring provider shall disclose, in writing, any ownership interest in the nonparticipating hospital or ambulatory surgical center.

E. 1. Except as authorized by law, no provider shall bill for services not personally rendered or directly supervised by the provider.

2. No provider shall bill for services that are not within the scope of the provider's specialty or within the scope of the licenses of the provider's supervised employees.

3. No provider shall falsely advise a patient that a referral required by Section 2505 of Title 63 of the Oklahoma statutes has been denied by the health plan.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

It shall be the responsibility of the provider who orders diagnostic testing to ensure that the patient is directly notified, in writing or verbally, of:

1. All diagnostic results including, but not limited to, lab and x-ray results within five (5) calendar days of availability of the results; and

2. Any significant abnormal diagnostic results within one calendar day of their availability and the proposed course of action the patient should take.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any health system, medical group, Independent Practice Association (IPA), or Management Services Organization (MSO), holding a full-risk bearing contract with a health plan, shall submit within forty-five (45) days following the close of any calendar quarter, an income statement, balance sheet and statement of cash flows, collectively called the “financial statements”, that disclose the financial condition of the medical group as of the last day of the last month of the calendar quarter. The financial statements shall be submitted to the health plan with which the medical group holds a full-risk bearing contract. The reviewed financial statements utilized shall have been prepared by an independent reviewer and shall be in accordance with generally accepted accounting principals. The financial statements shall bear the signature of the president or other appropriate officers of the full-risk bearing medical group. A health plan may request one additional, independent audit anytime during a fiscal year at the health plan’s expense.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any provider who is determined by the Insurance Commissioner to have violated any provision of the Health Care Consumer Protection and Fraud Prevention Act shall be subject to the following penalties:

1. Imposition of an administrative fine not to exceed One Thousand Dollars ($1,000.00), payable to the Anti-Fraud Unit of the Insurance Department, for each count or separate offense; and, if applicable,

2. Payment of a full and complete refund of all inappropriately billed fees and charges to the patient or third party payor, along with interest in the amount of fifteen percent (15%), to be calculated from the date of inappropriate billing.

B. 1. In the event a provider has inappropriately placed a patient account with a collection agency or an attorney for collection, it shall be the responsibility of the provider to:

a. refund all inappropriately billed fees and charges to the patient or third party payor,

b. reimburse all applicable court costs and fees, and

c. eradicate any incorrect entry or notation reported on the patient’s credit report.

2. The provider shall notify the credit reporting agency, in writing, of the incorrect entry to be eradicated and shall mail a copy of the written notification to the patient at the patient’s last known address.

SECTION 7. This act shall become effective November 1, 2002.

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