HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

HOUSE BILL 1810 By: Newton

AS INTRODUCED

An Act relating to prior authorization; amending Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.1), which relates to definitions; modifying a definition; amending 56 O.S. 2021, Section 4002.6, as last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.6), which relates to prior authorizations, other authorization requests, and requirements; modifying standard for requirements; removing certain requirements; and providing an effective date.

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

SECTION 1. AMENDATORY Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.1), is amended to read as follows:

Section 6570.1. As used in this act:

1. "Adverse determination" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's

requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated as defined by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition that lasts one (1) year or more and requires ongoing medical attention or limits activities of daily living or both;

3. "Clinical criteria" means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health care services;

4. "Emergency health care services", with respect to an emergency medical condition as defined in 42 U.S.C.A., Section 300gg-111, means:

a. a medical screening examination, as required under Section 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, or as would be required under such section if such section applied to an independent, freestanding emergency department, that is within the capability of the emergency department of a hospital or of an independent, freestanding emergency department, as applicable, including ancillary

services routinely available to the emergency department to evaluate such emergency medical condition, and

b. within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department, as applicable, such further medical examination and treatment as are required under Section 1395dd of the Social Security Act, or as would be required under such section if such section applied to an independent, freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished, as defined by 42 U.S.C.A., Section 300gg-111;

5. "Emergency Medical Treatment and Active Labor Act" or "EMTALA" means Section 1867 of the Social Security Act and associated regulations;

6. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents, as defined by Section ~~6592.1~~ 6592 of Title 36 of the Oklahoma Statutes;

7. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health care services" means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition, as defined by paragraph 2 of Section 1-1708.1C of Title 63 of the Oklahoma Statutes.

The term also includes the provision of mental health and substance use disorder services, as defined by Section 6060.10 of Title 36 of the Oklahoma Statutes, and the provision of durable medical equipment. The term does not include the provision, administration, or prescription of pharmaceutical products or services;

9. "Licensed mental health professional" means:

a. a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,

b. a psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry,

c. a physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act,

d. a clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists,

e. a professional counselor licensed pursuant to the Licensed Professional Counselors Act,

f. a person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act,

g. a licensed marital and family therapist as defined in the Marital and Family Therapist Licensure Act,

h. a licensed behavioral practitioner as defined in the Licensed Behavioral Practitioner Act,

i. an advanced practice nurse as defined in the Oklahoma Nursing Practice Act,

j. a physician assistant who is licensed in good standing in this state, or

k. a licensed alcohol and drug counselor/mental health (LADC/MH) as defined in the Licensed Alcohol and Drug Counselors Act;

10. "Medically necessary" means services or supplies provided by a health care provider that are:

a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,

b. in accordance with standards of good medical practice,

c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and

d. the most appropriate supply or level of service that can safely be provided to the enrollee as defined by Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or through the United States Postal Service or common carrier;

12. "Physician" means an allopathic or osteopathic physician licensed by the State of Oklahoma or another state to practice medicine;

13. "Prior authorization" means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. The term shall include "authorization", "pre-certification", and any other term that would be a reliable determination by a health benefit plan. The term shall not be construed to include or refer to such processes as they may pertain to pharmaceutical services;

14. "Urgent health care service" means a health care service with respect to which the application of the time periods for making an urgent care determination, which, in the opinion of a physician with knowledge of the enrollee's medical condition:

a. could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or

b. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

15. "Utilization review entity" means an individual or entity that performs prior authorization for a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes, but shall not include any ~~health plan offered by a contracted entity defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program or other~~ insurance subject to the Long-Term Care Insurance Act.

SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.6, as last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.6), is amended to read as follows:

Section 4002.6. A. A contracted entity shall meet all requirements established by the Oklahoma Health Care Authority pertaining to prior authorizations, all requirements shall align with the provisions of the Ensuring Transparency in Prior Authorization Act in Sections 6570.1 through 6570.11 of Title 36 of the Oklahoma Statutes. The Authority shall establish requirements that ensure timely determinations by contracted entities when prior authorizations are required including expedited review in urgent and

emergent cases that at a minimum meet the criteria of this section, and the Ensuring Transparency in Prior Authorization Act.

B. ~~A contracted entity shall make a determination on a request for an authorization of the transfer of a hospital inpatient to a post-acute care or long-term acute care facility within twenty-four (24) hours of receipt of the request.~~

~~C. A contracted entity shall make a determination on a request for any member who is not hospitalized at the time of the request within seventy-two (72) hours of receipt of the request; provided, that if the request does not include sufficient or adequate documentation, the review and determination shall occur within a time frame and in accordance with a process established by the Authority. The process established by the Authority pursuant to this subsection shall include a time frame of at least forty-eight (48) hours within which a provider may submit the necessary documentation.~~

~~D. A contracted entity shall make a determination on a request for services for a hospitalized member including, but not limited to, acute care inpatient services or equipment necessary to discharge the member from an inpatient facility within twenty-four (24) hours of receipt of the request.~~

~~E. Notwithstanding the provisions of subsection C of this section, a contracted entity shall make a determination on a request as expeditiously as necessary and, in any event, within twenty-four~~

~~(24) hours of receipt of the request for service if adhering to the provisions of subsection C or D of this section could jeopardize the member's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the contracted entity shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization.~~

~~F. Notwithstanding any other provision of this section, a contracted entity shall make a determination on a request for inpatient behavioral health services within twenty-four (24) hours of receipt of the request.~~

~~G.~~ A contracted entity shall make a determination on a request for covered prescription drugs that are required to be prior authorized by the Authority within twenty-four (24) hours of receipt of the request. The contracted entity shall not require prior authorization on any covered prescription drug for which the Authority does not require prior authorization.

~~H.~~ C. A contracted entity shall make a determination on a request for coverage of biomarker testing in accordance with Section 4003 of this title.

~~I. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the contracted entity shall provide the requesting provider, within seventy-two (72) hours of receipt of such issuance, with reasonable~~

~~opportunity to participate in a peer-to-peer review process with a provider who practices in the same specialty, but not necessarily the same sub-specialty, and who has experience treating the same population as the patient on whose behalf the request is submitted; provided, however, if the requesting provider determines the services to be clinically urgent, the contracted entity shall provide such opportunity within twenty-four (24) hours of receipt of such issuance. Services not covered under the state Medicaid program for the particular patient shall not be subject to peer-to-peer review.~~

~~J. The Authority shall ensure that a provider offers to provide to a member in a timely manner services authorized by a contracted entity.~~

~~K. The Authority shall establish requirements for both internal and external reviews and appeals of adverse determinations on prior authorization requests or claims that, at a minimum:~~

~~1. Require contracted entities to provide a detailed explanation of denials to Medicaid providers and members;~~

~~2. Require contracted entities to provide an opportunity for peer-to-peer conversations with Oklahoma-licensed clinical staff of the same or similar specialty within twenty-four (24) hours of the adverse determination; and~~

~~3. Establish uniform rules for Medicaid provider or member appeals across all contracted entities.~~

SECTION 3. This act shall become effective November 1, 2025.

COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES OVERSIGHT, dated 02/26/2025 – DO PASS.