ENGROSSED HOUSE
BILL NO. 3862

By: Ford, Sneed, and Sterling of the House

and

Standridge of the Senate

[ health insurance – terms – disclosure and review of prior authorization requirements – adverse determinations – personnel qualifications – consultations – requirements physicians – retrospective denial – exemptions – failure to comply – 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 6570.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this section:

1. "Prior authorization" means the process by which utilization 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 also includes any health insurer's or utilization review entity's

requirement that an enrollee or health care provider notify the health insurer or utilization review entity prior to providing a health care service; and

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

a. insurer that writes health insurance policies, and

b. a preferred provider organization, health maintenance organization, or exclusive provider organization.

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

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

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

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

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

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

B. The physician must:

1. Possess a current and valid nonrestricted license to practice medicine;

2. Be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request;

3. Have experience treating patients with the medical condition or disease for which the health care service is being requested; and

4. Make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who are responsible for the provision of health care services provided to enrollees of Oklahoma.

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

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

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

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

B. The physician must:

1. Possess a current and valid nonrestricted license to practice medicine;

2. Be currently in active practice in the same or similar specialty as a physician who typically manages the medical condition or disease for at least five (5) consecutive years;

3. Be knowledgeable of, and have experience providing, the health care services under appeal;

4. Not be employed by a utilization review entity or be under contract with the utilization review entity other than to participate in one or more of the utilization review entity's health care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

5. Not have been directly involved in making the adverse determination; and

6. Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the utilization review entity by the enrollee's health care provider, any relevant records provided to the utilization review entity by a health care facility, and any medical literature provided to the utilization review entity by the health care provider.

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

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

B. In the case of preventive care that has prior authorization approval, if it has been determined medically necessary by the medical provider that additional preventive care is needed, it shall

be covered under the initial pre-authorization. For any subsequently provided preventive care covered by the initial pre-authorization, it must be in connection to care furnished by the medical provider. Any care provided to an enrollee that is not in connection to pre-authorized preventive care shall need to receive pre-authorization approval.

C. A utilization review entity that has made an adverse determination of both a request for prior authorization and a subsequent appeal by an enrollee's health care provider may be subject to medical malpractice if it is found that the medical care furnished in accordance with a utilization review entity's approval of medical care deviated from accepted norms of practice in the medical community, the recommendation of an enrollee's health care provider, and causes an injury to the enrollee. A utilization review entity shall only be found liable for medical malpractice if documentation is provided that shows a utilization review entity undermined the judgment of the enrollee's medical provider and all relevant information utilized to support the initial request for prior authorization and appeal of the adverse determination.

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

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

A. A utilization review entity may not require a health care provider to complete a prior authorization for a health care service in order for the enrollee to whom the service is being provided to receive coverage if in the most recent twelve-month period, the utilization review entity has approved or would have approved not less than eighty percent (80%) of the prior authorization requests submitted by the health care provider for that health care service.

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

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

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

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

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

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

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

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

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

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

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

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

3. A statement of the duration of the exemption.

I. A utilization review entity shall not deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered such service received a prior authorization exemption, unless the rendering health care provider:

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

2. Failed to substantially perform the health care service.

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

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

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

Passed the House of Representatives the 12th day of March, 2024.

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Presiding Officer of the House
of Representatives

Passed the Senate the ___ day of _____, 2024.

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Presiding Officer of the Senate