STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

SENATE BILL 441 By: Montgomery

AS INTRODUCED

An Act relating to health insurance; defining terms; allowing health benefit plan to exempt certain health care provider from certain preauthorization requirement under certain circumstances; establishing process for preauthorization exemption; requiring plan to publish certain criteria; requiring plan to provide notice to a provider under certain circumstances; construing provision; establishing denial process of certain exemption; providing for recission of certain exemption; establishing appeal process; authorizing provider to request an independent review organization review appeal; establishing appeal determination as binding; prohibiting retroactivity; prohibiting plan from denying or reducing certain payment to provider under certain circumstances; 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 6890 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purposes of this act:

1. "Health benefit plan" means a health benefit plan offered by a Health Maintenance Organization (HMO) operating under the Health Maintenance Organization Act of 2003 pursuant to Section 6901 et seq. of Title 36 of the Oklahoma Statutes, including a contract between a health benefit plan and a provider to provide to a patient proposed medically necessary and appropriate health care services, and a health benefit plan offered by a Preferred Provider Organization (PPO) as defined pursuant to Section 6054 of Title 36 of the Oklahoma Statutes;

2. "Health care provider" or "provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes;

3. "Health care service" means a service as defined pursuant to Section 1219.6 of Title 36 of the Oklahoma Statutes;

4. "Independent review organization" means an independent review organization as defined pursuant to Section 6475.3 of Title 36 of the Oklahoma Statutes; and

5. "Preauthorization" means a determination by a health benefit plan, or person contracting with a health benefit plan, that a health care service proposed to be provided to a patient is medically necessary and appropriate.

B. A health benefit plan that uses a preauthorization process for health care services may exempt a health care provider from

obtaining preauthorization for a particular health care service. A health benefit plan shall evaluate whether a provider qualifies for an exemption from preauthorization requirements once every six (6) months. The exemption shall be granted if, in the most recent six-month evaluation period, the health benefit plan has approved or would have approved not less than ninety percent (90%) of the preauthorization requests submitted by the provider for the health care service.

C. A health benefit plan may continue an exemption under this subsection without evaluating whether the provider qualifies for an exemption for a particular evaluation period. A provider is not required to request an exemption from preauthorization to qualify under this act.

D. 1. A health benefit plan that provides any preauthorization exemption under this act shall post the criteria for such exemption on a publicly available website and a monthly updated list of health care providers who fall under the exemption.

2. A health benefit plan shall provide notice to a provider that is eligible for a preauthorization exemption no later than five (5) business days after the determination has been made. The notice shall include:

a. a statement that the provider qualifies for an exemption from preauthorization requirements,

b. a list of health care services and health benefit plans to which the exemption applies,

c. a statement of the duration of the exemption, and

d. a notification of the health benefit plan's payment requirements.

3. Nothing in this subsection shall be construed to authorize a provider to provide a health care service outside of the scope of the provider's applicable license or to require a health benefit plan to pay for a health care service that is performed in violation of the laws of this state.

E. A health benefit plan may deny an exemption from preauthorization only if the provider does not have the exemption at the time of the relevant evaluation period and if the health benefit plan provides the provider with sufficient data for the relevant preauthorization request period that demonstrates that the provider does not meet the criteria for the exemption.

F. If a provider is denied a preauthorization exemption or has the exemption rescinded pursuant to Section 2 of this act, the provider is eligible for consideration of an exemption for the same health care service immediately after the next evaluation period concludes.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6891 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan that complies with all other provisions of this act may rescind a provider's exemption from preauthorization requirements only during January or June of each year.

B. 1. A health benefit plan shall make the determination to rescind an exemption by using a retrospective review process for the most recent evaluation period. The review shall use a sample chosen at random of not fewer than five (5) and no more than twenty (20) claims submitted by the provider. If findings conclude that less than ninety percent (90%) of the sampled claims for the particular health service met the criteria used to previously grant the exemption, the recission process may commence.

2. For a determination to rescind a provider's exemption, the determination shall be made by an individual licensed to practice medicine in this state who has the same or a similar specialty as the provider under review.

3. A health benefit plan may only conduct a retrospective review of a healthcare service subject to an exemption if:

a. the health benefit plan has a reasonable cause to suspect a basis of denial exists under subsection A of this section, or

b. a review is needed to determine if the provider administering the exemption still qualifies for an exemption under this act; provided, however, this

subparagraph shall not be construed to modify or otherwise affect any other requirements placed upon a health benefit plan except those outlined in subsection A of Section 3 of this act.

C. 1. A provider's exemption from preauthorization requirements under this section shall remain in effect until thirty (30) days after the health benefit plan notifies the provider of the determination to rescind the exemption if the provider does not appeal the determination. The provider shall be notified not less than twenty-five (25) days before the proposed recission is to take effect. Notice shall include all relevant data and information used to make the determination including, but not limited to, the sample information from the relevant evaluation period and shall include a plain language explanation of the procedures for the provider to appeal the determination.

2. If the provider appeals the determination to rescind the preauthorization exemption, the exemption shall remain in effect until the fifth day after the date that an independent review organization affirms the determination to rescind the exemption.

D. A provider has the right to a review of a determination regarding the recission of a preauthorization exemption which shall be conducted by an independent review organization. A health benefit plan may not require any other internal appeal process before a provider can request a review of the determination. In

requesting a review, the provider may request that the independent review organization consider a different random sample under the same provisions of subsection B of this section.

E. 1. A health benefit plan is bound by an appeal or independent review determination that does not affirm the determination made by the plan to rescind a preauthorization exemption.

2. If a determination regarding a preauthorization exemption made by a health benefit plan is overturned by an independent review organization pursuant to a review, the health benefit plan shall not attempt to rescind the exemption before the end of the next evaluation period.

3. A health benefit plan may not retroactively deny a health care service because of a recission of an exemption under any circumstance.

F. An independent review organization shall complete the review of a determination regarding an exemption recission no later than the thirtieth day after the date that a provider files the request for a review under this section.

G. If a review of a determination by a health benefit plan is conducted pursuant to this section, the health benefit plan shall pay a fee pursuant to Section 19 of Title 76 of the Oklahoma Statutes to obtain access to patient medical records. The health

benefit plan shall pay for the appeal or independent review of an adverse determination regarding the preauthorization exemption.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6892 of Title 36, unless there is created a duplication in numbering, reads as follows:

A health benefit plan shall not deny or reduce payment to a health care provider for a health care service for which the provider has been exempted from preauthorization requirements under Section 1 of this act unless the provider:

1. Knowingly or materially misrepresented the health care service in a request for payment submitted to the health benefit plan with the specific intent to deceive or obtain an unlawful payment from the health benefit plan;

2. Failed to substantially perform the healthcare service;

3. Designates the incorrect entity responsible for payment;

4. Has already been paid for the procedures identified in the claim;

5. Submitted the claim fraudulently or the prior authorization was based in whole or part on erroneous information provided to the health benefit plan by the provider, patient, or other person not related to the health benefit plan; or

6. Performs a procedure or service on a patient who was not eligible to receive the procedure or service and the health benefit

plan did not know, and with the exercise of reasonable care could not have known, of his or her eligibility status.

SECTION 4. This act shall become effective November 1, 2023.

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