

SECTION 6907 OF THE HMO ACT OF 2003
Title 36 of the Oklahoma Statutes
Added by Laws 2003, Effective November 1, 2003

§36-6907. Reasonable standards of quality of care - Quality assurance plan and activities - Record of proceedings - Patient record system - Medical policy - Credentialing and recredentialing of health care providers - Termination or nonrenewal of contracts - Emergency services.

A. Every health maintenance organization shall establish procedures that ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services across all institutional and noninstitutional settings. The program shall include, but need not be limited to, the following:

1. A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

2. A written quality assurance plan that describes the following:

- a. the health maintenance organization's scope and purpose in quality assurance,
- b. the organizational structure responsible for quality assurance activities,
- c. contractual arrangements, where appropriate, for delegation of quality assurance activities,
- d. confidentiality policies and procedures,
- e. a system of ongoing evaluation activities,
- f. a system of focused evaluation activities,
- g. a system for credentialing and recredentialing providers, and performing peer review activities, and
- h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

3. A written statement describing the system of ongoing quality assurance activities including:

- a. problem assessment, identification, selection and study,
- b. corrective action, monitoring, evaluation and reassessment, and

- c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

4. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

5. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the State Commissioner of Health.

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization's evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the State Commissioner of Health or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the State Commissioner of Health.

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

G. The organization shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures, utilization review criteria and procedures, quality, credentialing and recredentialing criteria, and medical management procedures.

H. As used in this section "credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health maintenance organization. "Credentialing" or "recredentialing" may include, but need not be limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a health maintenance organization to permit initial or continued participation by a physician or other health care provider.

1. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application

required by Section 1-106.2 of Title 63 of the Oklahoma Statutes, with input from physicians and other health care providers.

2. Organizations shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the Council on Optometric Education.

4. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

5. A health maintenance organization (HMO) shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

6. In reviewing the application, the health maintenance organization (HMO) shall evaluate each application according to the plan's checklist of materials required in the application process.

7. When an application is deemed complete, the HMO shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

8. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health maintenance organization (HMO). Any malpractice carrier that fails to respond to an inquiry within the allotted time frame may be assessed an administrative penalty by the State Commissioner of Health.

9. Upon receipt of primary source verification and malpractice history by the HMO, the HMO shall determine if the application is a clean application. If the application is deemed clean, the HMO shall have forty-five (45) calendar days within which to credential

or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

10. If a health maintenance organization is unable to credential or recredential a physician or other health care provider due to an application's not being clean, the HMO may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the HMO is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the HMO within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

11. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

12. A health maintenance organization shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

13. Any HMO that violates the provisions of this subsection may be assessed an administrative penalty by the State Commissioner of Health.

I. Health maintenance organizations shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

J. Health maintenance organizations shall, upon request, provide to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Health maintenance organizations shall not contractually prohibit such requests.

K. No HMO shall engage in the practice of medicine or any other profession except as provided by law nor shall an HMO include any provision in a provider contract that precludes or discourages a health maintenance organization's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's HMO; or

2. Advocating on behalf of a patient before the HMO.

L. Decisions by a health maintenance organization to authorize or deny coverage for an emergency service shall be based on the

patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;
2. Impairment of bodily function; or
3. Dysfunction of any bodily organ or part.

M. Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO.

N. Health maintenance organizations shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the HMO contract.

O. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a health maintenance organization fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the HMO shall not deny coverage for the services due to lack of prior authorization.

P. The reimbursement policies and patient transfer requirements of a health maintenance organization shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of an HMO is transferred from a hospital emergency department facility to another medical facility, the HMO shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

Added by Laws 2003, c. 197, § 7, eff. Nov. 1, 2003.