

MANAGED CARE REFERRALS
Title 63 of the Oklahoma Statutes
As Amended in 2000, effective November 1, 2000

§63-2550.1. Definitions.

As used in Sections 2550.1 through 2550.4 of this title:

1. "Covered person" means an individual who receives medical care and treatment through a managed care plan. In the case of a minor child, the term includes the parent or legal guardian of the child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of that person;

2. "Degenerative and disabling condition or disease" means a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program or a high level of care, service, resources or continued coordination of care in the community;

3. "Designee of the covered person" means an individual designated by the covered person to represent the interests of the covered person, including the covered person's provider;

4. "Managed care plan" means a plan operated by a managed care entity, including the Oklahoma State and Education Employees Group Insurance Board, that provides for the financing and delivery of health care services to persons enrolled in such plan through:

- a. arrangements with selected providers to furnish health care services,
 - b. standards for the selection of participating providers,
 - c. organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution, and
 - d. financial incentives for persons enrolled in the managed care plan to use the participating providers and procedures provided for by the managed care plan;
- provided, however, the term "managed care plan" shall not include a preferred provider organization (PPO) as defined in Section 6054 of Title 36 of the Oklahoma Statutes, or a certified workplace medical plan as defined in Section 14.2 of Title 85 of the Oklahoma Statutes;

5. "Provider" shall have the same meaning as such term is defined by a health maintenance organization, an indemnity plan or a preferred provider organization; and

6. "Treatment plan" means a proposal developed for a covered person that is specifically tailored to the individual's treatment needs for a specific illness or condition, and that includes, but is not limited to:

- a. a statement of treatment goals or objectives, based upon and related to a medical evaluation,

- b. treatment methods and procedures to be used to obtain these goals, and
- c. identification of the types of professional personnel who will carry out the treatment procedures.

Added by Laws 1999, c. 361, § 1, eff. Nov. 1, 1999. Amended by Laws 2000, c. 292, § 4, eff. Nov. 1, 2000.

§63-2550.2. Referral to and treatment by specialist.

A. A managed care plan that has no participating provider for a covered benefit requiring a specialist shall arrange for a referral to a specialist with expertise in treating the covered benefit. The specialist shall agree to abide by the terms of the plan's provider contract if the terms are commensurate with the terms of contracts for similar specialists.

B. 1. A managed care plan shall include procedures by which a covered person in a managed care plan, upon diagnosis by a primary care provider of a condition that without specialized treatment would result in deleterious outcomes that would threaten life or limb or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may be referred to a specialist with expertise in treating such condition or disease.

2. The specialist may be responsible for and may provide and coordinate the covered person's primary and specialty care only if the specialist is willing to abide by the terms of the plan's contract and capable of providing such care.

3. If the managed care plan, or the primary care provider in consultation with the managed care plan and the specialist, if any, determines that the most appropriate coordinator of the covered person's care is a specialist, the managed care plan shall authorize a referral of the covered person to the specialist. In no event shall a managed care plan be required to permit a covered person to elect treatment by a nonparticipating specialist, except pursuant to the provisions of subsection A of this section.

C. 1. A referral pursuant to this section shall be pursuant to a treatment plan agreed to by the managed care plan, the specialist and the primary care provider which complies with the covered benefits of the health plan and which is developed in consultation with the primary care provider, if appropriate, the specialist, and the covered person or the designee of the covered person.

2. Subject to the terms of the treatment plan agreed to by the managed care plan, the specialist and the primary care provider and subject to the terms of the plan's contract, a specialist shall be permitted to treat the covered person without a referral from the covered person's primary care provider and may authorize referrals, procedures, tests and other medical services as the covered person's

primary care provider would otherwise be permitted to provide or authorize.

3. If a managed care plan refers a covered person to a nonparticipating specialist, services provided pursuant to the treatment plan shall be provided pursuant to the provisions of subsection A of this section at no additional cost to the covered person beyond what the covered person would otherwise pay for services received within the network of the managed care plan.

D. A managed care plan shall implement procedures for a standing referral to a specialist if the primary care provider determines in consultation with the specialist and the managed care plan that a covered person needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan that complies with covered benefits of the managed care plan.

Added by Laws 1999, c. 361, § 2, eff. Nov. 1, 1999.

§63-2550.3. Termination of participating providers - Procedures and conditions.

A. Every managed care plan shall establish procedures governing termination of a participating provider who is terminated for reasons other than cause. The procedures shall include assurance of continued coverage of services, at the contract terms and price by a terminated provider for up to ninety (90) calendar days from the date of notice to the covered person, for a covered person who:

1. Has a degenerative and disabling condition or disease;
2. Has entered the third trimester of pregnancy. Additional coverage of services by the terminated provider shall continue through at least six (6) weeks of postpartum evaluation; or
3. Is terminally ill.

B. 1. If a participating provider voluntarily chooses to discontinue participation as a network provider in a managed care plan, the managed care plan shall permit a covered person to continue an ongoing course of treatment with the disaffiliated provider during a transitional period:

- a. of up to ninety (90) days from the date of notice to the managed care plan of the provider's disaffiliation from the managed care plan's network, or
- b. that includes delivery and postpartum care if the covered person has entered the third trimester of pregnancy at the time of the provider's disaffiliation.

2. If a provider voluntarily chooses to discontinue participation as a network provider participating in a managed care plan, such provider shall give at least a ninety-day notice of the disaffiliation to the managed care plan. The managed care plan

shall immediately notify the disaffiliated provider's patients of that fact.

3. Notwithstanding the provisions of paragraph 1 of this subsection, continuing care shall be authorized by the managed care plan during the transitional period only if the disaffiliated provider agrees to:

- a. continue to accept reimbursement from the managed care plan at the rates applicable prior to the start of the transitional period as payment in full,
- b. adhere to the managed care plan's quality assurance requirements and to provide to the managed care plan necessary medical information related to such care, and
- c. otherwise adhere to the managed care plan's policies and procedures, including, but not limited to, policies and procedures regarding referrals, and obtaining preauthorization and treatment plan approval from the managed care plan.

Added by Laws 1999, c. 361, § 3, eff. Nov. 1, 1999.

§63-2550.4. Nonformulary or prior-authorized drugs - Approval.

A. A managed care plan that has a closed formulary or that requires prior authorization to obtain certain drugs shall approve or disapprove a provider's or a covered person's request for a nonformulary drug or a drug that requires prior authorization within twenty-four (24) hours of receipt of such request.

B. If the managed care plan does not render a decision within twenty-four (24) hours, the provider or covered person shall be entitled to a seventy-two-hour supply of the drug. The managed care plan shall then approve or disapprove the request for a nonformulary drug or prior authorized drug within the additional seventy-two-hour period.

C. Failure of the managed care plan to respond within the subsequently allowed seventy-two-hour period shall be deemed as approval of the request for the nonformulary drug or prior authorized drug; provided, however, the approval shall be subject to the terms of the managed care plan's drug formulary; provided further, the purchase of the approved drug shall be at no additional cost to the covered person beyond what the covered person would otherwise pay for a prescription pursuant to the managed care plan.

D. All providers and covered persons in a managed care plan shall be provided with a copy of the plan's drug prior authorization process upon initial contracting or enrollment and at the time of enactment of any subsequent changes to the process.

Added by Laws 1999, c. 361, § 4, eff. Nov. 1, 1999.