TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 657. CERTIFIED WORKPLACE MEDICAL PLANS

"Unofficial Version"

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SUBCHAPTER 1. GENERAL PROVISIONS

310:657-1-1. Purpose

This chapter provides for certification of the workplace medical plan under three (3) laws. Those laws are 85 O.S. Supp. 1996, Section 14.3, 63 O.S. Supp. 1996, Sections 1-101 et seq. (Oklahoma Public Health Code), and 75 O.S. Supp. 1996, Sections 250.1 through 323 (Administrative Procedures Act).

310:657-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the Workers' Compensation Act, Title 85 of the Oklahoma Statutes.

"Commissioner" means the Commissioner of Health.

"Department" means the Oklahoma State Department of Health.

"Facility" means a licensed, certified or accredited institution or health care setting which renders prescribed medical or health care service.

"Health professional" means an individual who is licensed or otherwise authorized under applicable laws, rules or standards to deliver medical or health services.

"Insurer" means a self-insured employer, a group self-insurance association plan, or an employer's workers' compensation insurance carrier.

"Peer" means a health professional who holds a non-restricted license in Oklahoma or another state and practices a similar specialty as typically manages the service under review.

"Person" means an individual, partnership, association, corporation, or other public or private legal entity including an agency.

"Plan" means a workplace medical plan.

"Provider" means any health professional, facility or other entity licensed or otherwise authorized under applicable laws, rules or standards to furnish medical or health service.

310:657-1-3. Severability

If any subchapter or paragraph of OAC 310:657 shall be ruled invalid, such judgment shall not affect any other subchapter or paragraph. The remaining subchapters and paragraphs shall remain in full force.

SUBCHAPTER 3. PROVIDER CREDENTIALING

310:657-3-1. General considerations

The Plan's credentialing program shall ensure that each provider is competent and qualified to offer medical or health services. A Plan may use other criteria in deciding which of the properly credentialed providers shall be selected to participate in the Plan.

310:657-3-2. Credentialing responsibilities

(a) The Plan shall credential each provider under written policies, and shall complete credentialing before the provider's contract becomes effective. The Plan shall not list the provider in the provider directory or marketing materials until credentialed.

(b) The Plan shall establish a body of professional peers to review and approve the Plan's credentialing policies. A health professional designated by the Plan shall oversee credentialing.

(c) The Plan shall obtain proof of the applicant's current authority to practice a health profession. Proof shall be based on evidence from the source issuing the credential. The Plan shall retain all records and documents on a provider for at least five (5) years. Nothing in OAC 310:657-3 requires public disclosure of information which is confidential following applicable law.

(d) At least once every five (5) years, the Plan shall verify the professional's authority to practice.

310:657-3-3. Provider review process

(a) A provider who is subject to credentialing shall have the right to review all credentialing information obtained by the Plan, and to review the credentialing procedures.
(b) The Plan shall advise the provider of any information that does not meet the Plan's credentialing standards.
(c) Each Plan shall have an appeal process by which a provider may submit additional information and request further review.

SUBCHAPTER 5. QUALITY ASSURANCE

310:657-5-1. Purpose and intent

The Plan shall assure the quality of its services using, at least, a system of quality assessment and quality improvement. The Plan shall ensure that all providers participate in quality assurance activities.

310:657-5-2. Quality assessment and quality improvement

(a) The Plan, either directly or through contract, shall maintain a quality assessment and improvement system. The system shall have at least these features:
(1) Systematic collection and analysis of data, including measures of provider performance; and
(2) Activities to foster continuous improvement of services provided to injured workers, including:
(A) identifying practices which result in positive health outcomes; and
(B) integrating information sources such as service management, claims processing, worker satisfaction and grievances.
(3) Organizational support for the system with input from the medical director;
(4) Methods of evaluating performance improvement activities.
(b) The quality assessment and improvement system shall include the following functions, done at least annually:
(1) An analysis of care patterns in the following priority areas:
(A) Services likely to affect many injured workers;
(B) Procedures that could place the health of injured workers at risk;
(C) Variations in practice patterns; and
(D) Underuse and overuse of medical and health services;
(2) An evaluation of access to medical and health services.

310:657-5-3. Reporting and disclosure requirements

The Plan, either directly or through contract, shall document and communicate information about quality assurance.

(1) In marketing materials the Plan shall include a summary of its quality assurance activities.

(2) The Plan shall make available to the employee, a description of its quality assurance process and a statement of employee rights in the Plan.

(3) The Plan shall share information with its regulatory agencies, providers and the public about its quality assurance activities and progress.

310:657-5-4. Inspections

(a) For purposes of conducting the site visit, the Department may inspect any person, or the business of any person, insofar as such inspection is necessary or material to the investigation of the Plan.

(b) The refusal of any Plan by its officers, directors, employees or agents to submit to the inspection or to comply with any reasonable written request of the inspectors shall be grounds for suspension, revocation or nonrenewal of any certification or authority held by the Plan to engage in business subject to the Department's jurisdiction.

(c) In the case of a annual site visit, the Department may provide advance notice of not longer than 15 working days to the Plan by telephone and/or written means of communication.

(1) Such notification may include a request for the Plan to provide case, dispute and/or grievance listings to the Department to allow Department consideration and possible selection of samples prior to arriving at the Plan's office.

(2) In advance of an announced site visit or upon arrival of an unannounced site visit, the Department may request to have Plan materials and personnel available which includes, but not limited to the following:

(A) Current Organizational Chart;

(B) Listing of current personnel and those person's direct-dial telephone numbers or extensions;

(C) Assignment of a single Plan representative to serve as the Department's primary contact during the course of the on-site inspection;

(D) Current Master Client Report, or other comprehensive listing of contracts currently or previously in place, including counts of CWMP participants;

(E) Current listing of contracted Insurers and/or Insureds; and

(F) Assignment of one or more persons to:

(i) Conduct a preliminary walk-through tour of the offices;
(ii) Explain to the Department staff how physical files are arranged;
(iii) Explain to the Department staff what files are electronic only and will require a Department request to the Plan's primary contact person for printing or visual inspection;
(iv) Explain the process for entering or leaving the Plan's office;
(v) Explain how case management is assigned;
(vi) Explain how the Plan monitors caseloads;
(vii) Explain how the Plan receives cases from the payer.

(G) Provision for Departmental file reviews, of any written:
(i) Case management policies and procedures;
(ii) Utilization review policies and procedures;
(iii)Case management forms;
(iv) Utilization review forms;
(v) Case management form letters;
(vi) Utilization review letters;
(vii)Communication standards;
(viii)Account specific instructions;
(ix) List of all routine audits or other QA procedures; and
(x) List of the prior periods' explicit Medical Director or Peer Reviews.

(H) Specific personnel, by title, that the Department initially anticipates interviewing during the course of the site visit to ensure that those persons will be available.

(I) Such other material that the Department requires to be assembled for inspection such as Policies and Procedures changed since the last application for certification or renewal.

(d) The Department is not required to provide advance notice of a site visit to a Plan in an instance where the Department has reason to believe that the Plan is either:
(1) Not operating in accordance with its application, the Act, or OAC 310:657; or
(2) Not adequately providing a claimant(s) with medical services or medical management.

(e) Upon the completion of the site visit and review of the findings, the Department shall prepare a report with a determination that a Plan is or is not operating in accordance with its latest application. This report may also include recommendations for follow-up and/or corrective actions.

(f) The Plan shall not issue marketing or solicitation materials that advertise, identify or judge the results of an investigation completed by the Department.

SUBCHAPTER 7. UTILIZATION REVIEW

310:657-7-1. Purpose and intent

(a) The Plan's utilization review program shall assist the manager in providing services to an individual injured worker and shall assist administrators in delivering services to all employees.

(b) Nothing in OAC 310:657-7 restrains a Plan or provider from supplying information to any person required by the Act.

310:657-7-2. Scope and content of utilization review

(a) The Plan shall implement a utilization review program that describes all delegated and non-delegated review activities for covered services. The program shall include:

(1) Procedures to evaluate service need, appropriateness and efficiency, with processes to detect service underuse and overuse;

(2) Data sources and review criteria used to determine the need for, and appropriateness of, medical and health services;

(3) Processes for resolving disputes on medical or health services;

(4) Consistent application of criteria and decisions;

(5) Data collection and analytical methods that may be used to assess use of health care services;

(6) Provisions for ensuring confidentiality of information;

(7) Reports to the governing body or its designee; and

(8) Day-to-day program management.

(b) The Plan shall file with the Commissioner an annual report summarizing utilization review activities. The data shall preserve the confidentiality of information about individual workers. The Commissioner may request additional information based on material in the report.

310:657-7-3. Operational requirements

(a) The utilization review program shall have criteria that are based on evidence and regularly evaluated.

(1) Practicing providers shall be involved in developing the review criteria.

(2) After refusing to authorize a service, the Plan shall provide the review criteria for that service upon request to affected providers, the injured worker, and the Commissioner.

(b) Qualified providers shall supervise the utilization review program. A licensed, board-certified clinical provider shall

evaluate the appropriateness of any decision to deny a service to an injured worker.
(c) Decisions on whether or not to authorize services shall be issued following the requirements of OAC 310:657-7-4.
(1) Decisions shall be made using pertinent information and consulting with the treating provider.
(2) The Plan shall ensure that reviewers consistently apply criteria.
(d) The Plan shall routinely assess the effectiveness of the utilization review program.
(e) Data systems shall be sufficient to support utilization review activities.
(f) If the Plan delegates any activities to a utilization review organization, adequate oversight shall be maintained that includes:
(1) A description of utilization review organization activities, including reporting requirements;
(2) Formal approval of the utilization review organization's program by the Plan; and
(3) Evaluations of the utilization review organization.
(g) Utilization review shall be coordinated with other medical management activities.
(h) The Plan or its utilization review organization shall provide toll-free telephone access to its staff during normal business hours.
(i) When conducting utilization review, the Plan or utilization review organization shall collect only information necessary for assessing the appropriateness of, and need for, services.

310:657-7-4. Utilization review decision
(a) The Plan shall complete any individual decision to authorize or deny a non-emergency service within two (2) working days after obtaining all necessary information. Necessary information includes any clinical evaluation of an injured worker by a provider other than the one originally recommending a proposed service.
(b) The Plan shall notify the provider by telephone within twenty-four (24) hours after the decision to authorize or deny a service. The Plan shall send confirmation of the decision within two (2) working days after deciding.
(c) If the injured worker is an inpatient or undergoing treatment, the Plan shall communicate to the provider any decision to authorize or deny the service by telephone within twenty-four (24) hours after the decision. The Plan shall send confirmation to the provider within two (2) working days after deciding. A decision on an extended stay shall identify the additional number of days or services approved.

(d) A decision to authorize or deny coverage for an emergency service shall be based on the patient's presenting symptoms.

310:657-7-5. Denial of service

(a) A decision to deny a service shall be clearly documented, including specific bases for the action. Confirmation shall be sent to the provider within two (2) working days after the decision. If the Plan is aware that the request for service was initiated by the injured worker, the Plan shall send written notice to the injured worker within two (2) working days after the decision.

(b) A decision to deny a service after the service has been provided to an injured worker shall be issued in writing within five (5) workings days after obtaining all necessary information.

(c) Written notice of a decision to deny a service shall describe the dispute resolution procedures.

310:657-7-6. Dispute resolution procedures

(a) The Plan shall have procedures for dispute resolution on issues related to medical care under the Plan. This procedure may be different than the grievance procedure for resolving matters not directly related to medical care under the Plan. A dispute resolution procedure shall be available to the injured worker and to the attending or ordering provider.

(b) The Plan's procedure shall be designed to resolve each dispute within ten (10) days after receipt, unless information is not available in the normal course of business.

(c) Each dispute shall be evaluated by an appropriate peer or another licensed health professional as mutually agreed by the parties. The evaluating professional shall not have been involved in the initial decision to deny a service.

(d) The Plan shall notify the injured worker and affected provider of its decision.

(e) An injury requiring emergency services shall be treated immediately, without regard for the ten (10) day dispute resolution period.

310:657-7-7. Disclosure requirements

(a) In materials provided to insurers, insureds and employees, the Plan shall include a summary of its utilization review procedures.

(b) The Plan shall clearly disclose employee rights and responsibilities relating to quality assurance and utilization review.

(c) The Plan shall provide to employees a toll-free telephone number for information about the Plan's utilization review program.

SUBCHAPTER 9. GEOGRAPHIC SERVICE AREAS

310:657-9-1. Access to providers

(a) The Commissioner shall presume a proposed service area to be reasonable if the mean travel time is thirty (30) minutes or less from six (6) points on the area boundary to the nearest primary care delivery sites in that area, and sixty (60) minutes or less to specialty service providers.

(b) The Commissioner may approve a service area with travel times of greater than thirty (30) minutes to primary services, or sixty (60) minutes to specialty services, based on the following:

(1) Providers are not available in the area;

(2) Providers are available but do not meet the Plan's reasonable credentialing requirements;

(3) Providers are unwilling or unable to enter a reasonable health services contract with the Plan;

(4) Residents of the area customarily travel longer times to reach medical and health providers; or

(5) Providers have access to air ambulance services to transport injured workers.

(c) OAC 310:657-9 shall be construed to foster Plans in all areas of Oklahoma. These provisions shall not be interpreted to threaten the health and safety of employees or to impair the present system of service delivery in Oklahoma.

310:657-9-2. Required filings

(a) The Plan shall provide the information required in OAC 310:657-9 in its initial application. Before any change of the service area, the Plan shall file the revised information in an application to amend or renew the certificate. All marketing materials produced by the Plan shall specify the approved geographic service area.

(b) The Plan shall describe its proposed service area using zip codes or other geographic units.

(c) The Plan shall provide a map of the service area showing the area boundaries, main traffic arteries and physical barriers. The Plan shall show the locations of primary and specialty providers. The Plan shall mark six (6) points along the boundary. The Plan shall calculate mean travel time from those points to the nearest primary care service sites. The Plan also shall calculate the mean travel time from the six (6) points to the nearest specialty care service sites.

310:657-9-3. Access to services

(a) Medical and health services shall be provided or arranged in the service area by the Plan.

(b) Services shall be available to the Plan's employees with reasonable promptness considering:

(1) Geographic location, hours of operation, and provisions for after-hours services; and

(2) Staffing patterns and types of providers.

(c) A Plan whose service area is located in a nonmetropolitan area may provide service outside its area if:

(1) The service is not primary or emergency care; and

(2) Providers in the area are not sufficient to offer the service.

(d) The Plan shall ensure continuity of services using at least the following:

(1) A provider responsible for coordinating the employee's services; and

(2) A system to report on eligibility and services rendered to the injured worker.

SUBCHAPTER 11. GRIEVANCE SYSTEM

310:657-11-1. Grievance system required

Each Plan shall maintain a system to resolve grievances.

310:657-11-2. Grievance forms

A Plan shall provide a grievance form for any enrollee, employer, insurer, insured or provider who wishes to file a written grievance. The form shall include information about the grievance system to help the person in completing and filing the form. Nothing in OAC 310:657 prevents a Plan from using other methods, such as a toll-free telephone line, to correct problems before the employee files a written grievance.

310:657-11-3. Time frames

The grievance system shall require an initial response within seven (7) days after a grievance is filed with the Plan. A grievance shall be resolved or finally determined by the Plan within ninety (90) days after the grievance is filed. This period may be extended if the Plan encounters a delay in obtaining the documents or records necessary to reach a decision on the grievance. The ninety (90) day time frame may be extended also by written agreement between the Plan and the person filing the grievance.

310:657-11-4. Effect of arbitration

If a grievance may be resolved through arbitration, the person filing the grievance shall be notified of the terms of arbitration. Any Plan that makes binding arbitration a condition

of a contract shall fully disclose this requirement in the contract and in any summaries.

310:657-11-5. Request for assistance

The Commissioner shall provide a form which any person may use to register dissatisfaction with the Plan. The Commissioner shall review such filings and consider whether or not the Plan complies with the Act and OAC 310:657. If the Commissioner has no reason to believe that a Plan violated the Act or OAC 310:657, the Plan's action shall be upheld. If the Commissioner has reason to believe that a violation exists, then the Commissioner shall consider the matter under 310:657-25.

SUBCHAPTER 13. OWNERSHIP AND CONTROL OF A PLAN

310:657-13-1. Ownership

The Plan's ownership, control and management shall have the knowledge, skills and experience that will make the Plan's operation beneficial to employees. The Commissioner shall not grant or renew a certificate when the Plan's ownership, control, or management is under the control of any person whose operations are or have been marked by the following:

(1) business practice or conduct that is to the detriment of the public, stockholders, investors, or creditors; or

(2) improper manipulation of assets or accounts.

310:657-13-2. Removal or transfer of property

(a) No Plan shall remove its property or business from Oklahoma without the Commissioner's written approval.

(b) No Plan shall attempt to transfer its property or merge with any other person without first obtaining the Commissioner's written approval.

310:657-13-3. Accounts, books and records

Each Plan shall maintain proper accounting controls including correct and complete records of accounts. Such records shall be available to the Commissioner during normal business hours.

310:657-13-4. Governing body oversight

The Plan's governing body or its designee shall be responsible for quality assurance, quality improvement, and utilization review actions. The governing body or designee shall approve and regularly evaluate these programs. If the Plan contracts with other entities to operate these programs, then the governing body or designee may consider reports from those entities instead of conducting its own evaluations. The governing body or designee

shall receive reports of quality assurance, quality improvement and utilization review actions at least once every six (6) months.

310:657-13-5. Ownership and control safeguards

The Plan shall safeguard the fairness and equity of medical and health service delivery if an insurer or an insured:

(1) Directly participates in the Plan's formation or certification;

(2) Occupies a position as the Plan's director, governing member, officer, agent, or employee;

(3) Has any ownership, financial or investment interest in the Plan;

(4) Has any contract with the Plan that limits the Plan's ability to accept business from any other source; or

(5) Has any relationship with a Plan, other than a contract for provision of medical and health services under the Act.

SUBCHAPTER 15. FINANCIAL REQUIREMENTS

310:657-15-1. Net worth requirement

(a) The Plan's net worth shall be calculated as assets minus liabilities, plus fully subordinated debt.

(b) The Plan shall maintain a positive net worth and shall maintain working capital to meet its obligations as they become due.

310:657-15-2. Applicability

The financial requirements in OAC 310:657-15-3 through OAC 310:657-15-10 shall apply to a Plan unless it demonstrates that a requirement does not apply. To decide if a requirement applies, the Commissioner shall consider the Plan's organizational structure, financial arrangements, fiduciary responsibilities, accounting controls and risk sharing arrangements.

310:657-15-3. Errors and omissions policy

(a) Each Plan shall file evidence of an errors and omissions policy to protect insurers, insureds and enrollees financially from the Plan's errors.

(1) The policy shall be no less than five hundred thousand dollars ($500,000) annual aggregate for all claims made during the policy period.

(2) The policy shall remain in force for at least two (2) years after certification ends.

(b) Such policy shall be issued by an entity licensed or approved by the Oklahoma Insurance Commissioner, to:

(1) Do business in this state; and

(2) Issue errors and omissions policies.

(c) Such policy shall be continuous in form, or renewed annually. If renewed annually, evidence of renewal shall be provided to the Commissioner each year. The Plan shall ensure that the Commissioner is notified of:

(1) Any lapse in coverage; or

(2) Termination of coverage at least thirty (30) days before termination.

310:657-15-4. Fidelity bond [REVOKED]

310:657-15-5. Preference of claims [REVOKED]

310:657-15-6. Liability insurance

In addition to the errors and omissions insurance policy each Plan shall have liability insurance coverage to protect the interests of injured workers. The insurance may include excess or stop loss, medical malpractice, and general liability coverage.

310:657-15-7. Provider contracts [REVOKED]

310:657-15-8. Projections

(a) The Commissioner may require a Plan to submit updates of projections required by OAC 310:657-21-4(1)(K). Each update shall explain any significant variance between operating results and previously forecast amounts.

(b) The Commissioner may request a revision of a financial projection that is inconsistent with the Plan's historic performance.

310:657-15-9. Impairment

(a) A Plan with less than the minimum required net worth shall be considered an impaired Plan.

(b) The Commissioner shall determine the amount of impairment. The amount of impairment may be based on a financial statement made by a Plan or on an examination report. The Commissioner shall require the Plan to eliminate the impairment within ninety (90) days. If the Plan does not eliminate the impairment, the Commissioner may revoke the Plan's certificate.

SUBCHAPTER 17. CONTRACTS AND SERVICE EXPLANATIONS

310:657-17-1. Purpose

The purpose of this subchapter is to ensure that a Plan furnishes to each insurer, insured, or provider a complete and understandable copy of their agreement. The contract shall not contain unjust, unfair, misleading or deceptive provisions.

310:657-17-2. Contents of the insurers' or insureds' contract

Each contract shall contain a clear statement of the following:

(1) Plan's name and address;
(2) Eligibility requirements;
(3) Medical and health services in the area;
(4) Emergency care services and procedures for authorizing emergency services by non-Plan providers;
(5) Out of area services;
(6) Limits and excluded items;
(7) Employee termination;
(8) Employee reinstatement;
(9) Claims procedures, if any;
(10) Dispute resolution and grievance procedures;
(11) Continuing coverage;
(12) Extension of benefits;
(13) Substitution of creditors;
(14) Geographic service area;
(15) Entire contract provision;
(16) Term of coverage;
(17) Renewing contract;
(18) Canceling contract;
(19) Reinstatement of contract;
(20) Grace period; and
(21) Conformity with state law.

310:657-17-3. Provider directory

(a) The Plan shall ensure that each insurer or insured with which it contracts receives a copy of the directory of providers.
(b) The provider directory may be filed as part of the contract to satisfy the Plan's obligation to provide a statement of services, procedures and requirements.
(c) The provider directory shall not contain summaries, provisions or statements which are unfair, unjust, misleading or deceptive.

310:657-17-4. Commissioner review

(a) No contract, provider directory or amendment shall be delivered or issued unless the Commissioner has approved its form.
(b) Each contract form shall be filed with the Commissioner at least thirty (30) days before delivery or issue. The Commissioner may extend the period for review for an additional thirty (30) days. The form is approved if the Commissioner takes no action at the end of the review period. The Plan shall notify the Commissioner in writing before using a form approved by the Commissioner's lack of action.
(c) After at least thirty (30) days notice, the Commissioner may withdraw approval of any form for cause shown.

(d) When a filing is disapproved or when approval is withdrawn, the Commissioner shall give the Plan written notice of the reasons for disapproval. The notice shall inform the Plan that within thirty (30) days after receipt of the notice the Plan may request a hearing. The hearing shall be conducted under the Administrative Procedures Act.
(e) The Commissioner may require supporting information in determining whether to approve or disapprove a filing.

310:657-17-5. Service changes

Each Plan shall provide a notice of any service changes to each insurer or insured with which it contracts. The notice shall identify the proposed services which differ from the current services. Such notice shall be provided at least thirty (30) days before the effective date of the change.

310:657-17-6. Provider contracts

(a) Each contract between a Plan and a participating provider shall be in writing. The contract shall state that an injured worker shall not owe any sums otherwise due from the Plan, insurer or insured under the contract.
(b) The contract shall set penalties against any provider who attempts to collect from an injured worker any sums owed by the Plan, insurer or insured under the contract.
(c) No participating provider, agent, trustee or assignee shall attempt to collect from an injured worker any sum owed by the Plan, insurer or insured under the contract.

SUBCHAPTER 19. CONFIDENTIALITY

310:657-19-1. Responsibility of Plan

(a) Worker-specific injury information and provider-specific performance data are confidential and the Plan shall implement procedures to ensure that confidentiality. The procedures shall include:
(1) Safeguards to protect against unauthorized disclosure; and
(2) Provisions that any party making information available to the public is responsible for failure to comply with a standard of due care.
(b) Information about the diagnosis, treatment or health of any injured worker shall be disclosed only to authorized persons. Release of information shall be permitted only with the written consent of the injured worker, or as needed for the Commissioner to enforce the Act and OAC 310:657. Nothing in OAC 310:657 shall prevent disclosure as otherwise required by law.

310:657-19-2. Responsibility of Commissioner

(a) The Commissioner shall hold in confidence any information about an injured worker and the information shall not be disclosed to any person except under these circumstances:

(1) When necessary to administer OAC 310:657;

(2) Upon the written consent of the worker;

(3) Following law or court order for the production or discovery of evidence; or

(4) When a claim or dispute between the worker and the Plan makes such information pertinent.

(b) Information considered by a medical or health services review committee and its records which are used by the Commissioner shall be confidential.

SUBCHAPTER 21. APPLYING FOR A CERTIFICATE

310:657-21-1. Application required

(a) Each Plan shall apply for a certificate on forms provided by the Commissioner.

(b) The person responsible for providing or arranging all required Plan services shall be the applicant for the certificate.

310:657-21-2. Deadlines for filing

(a) The application shall be filed by the Plan and approved by the Department before beginning operations.

(b) The application shall be filed at least thirty (30) days before a transfer of ownership of an existing Plan.

(c) The Plan shall apply to renew the certificate every five (5) years. The application to renew a certificate shall be filed at least thirty (30)days before the certificate expires.

(d) The Commissioner shall notify the applicant of incomplete items within thirty (30) days after receipt of the application. The applicant shall provide additional information within ninety (90) days after receipt of the notice. Failure to submit the requested information shall result in dismissal of the application. The Commissioner and the applicant may mutually agree to extend the deadline up to ninety (90) days.

310:657-21-3. Where to file

The application and the filing fee shall be delivered or mailed to the Department. The effective date of filing shall be the date the application and fee are received by the Department.

310:657-21-4. Description of application form

Each application for a certificate shall be accompanied by a non-refundable filing fee. The filing fee shall be the fee set in the Act. The fee shall be paid by check to the Oklahoma State Department of Health.

(1) The application for a certificate requests the following:
(A) A general description of the Plan and its operations, including the locations, types, and hours of providers;
(B) A copy of the Plan's basic organizational document, such as the articles of incorporation or association, partnership or trust agreement, and all amendments;
(C) A copy of bylaws or similar document, regulating the Plan's conduct;
(D) A list of names, addresses, and official capacities of all persons responsible for the Plan, including:
(i) Each corporate officer and director of a corporation; each manager of Limited Liability Company; those owners of a corporation, the partners or associates of a partnership or association, or members of a Limited Liability Company that own five percent (5%) or more of the stock or controlling interest in the Plan, Corporation, Partnership, Association, or Limited Liability Company; and of the person who will be the day-to-day Plan administrator; and
(ii) Disclosure of any contracts or arrangements between them and the Plan, including any appearance of a conflict of interest;
(E) The medical director's name, address, phone number, Oklahoma license number, and biographical information and address;
(F) The name and biographical information of the person who will be the day-to-day Plan administrator and address;
(G) A description of the geographic areas to be served;
(H) A description of any facilities to be used;
(I) The categories and names of all participating providers and facilities;
(J) The policies for credentialing and selection of providers;
(K) Projections for five (5) years which include employee population, primary physician to employee ratios, specialty care, laboratory, x-ray and hospital services, and revenues and expenses;
(L) A financial statement for the Plan prepared in accordance with accounting principles generally accepted in the United States of America, and related documents showing the Plan's financial capabilities;
(M) Forms of all provider and service contracts;
(N) Forms of all contracts with insurers and insureds, showing the services to which employees are entitled;
(O) Proposed marketing or advertising materials;

(P) Descriptions of the case management, utilization review and quality assurance processes, including treatment protocols, adopted by the Plan;
(Q) A description of the Plan's or providers' medical record system;
(R) Policies for developing and reporting data;
(S) Policies for dispute resolution and grievance reviews;
(T) A plan for an employee education program;
(U) A description of the financial incentives to be used to reduce costs and control use;
(V) A description of the Plan's workplace health and safety consultative services for employers;
(W) The provider directory;
(X) Contact person's name, address and telephone number; and,
(Y) Such other information as may be prescribed by the Commissioner in the application for a certificate.

(2) The application to renew a certificate requests the following:
(A) Any changes in the information provided in OAC 310:657-21-4; and
(B) Data on the Plan's experience, including revenues and expenses, changes in financial position, employee population per month, hospital days and ambulatory encounters per injured worker, encounters by type of health professional, disputes and grievances processed, peer review, quality control, medical records and utilization review systems.

(3) The Commissioner may require such other information as necessary to decide on the application.

SUBCHAPTER 23. APPROVAL OR DENIAL OF APPLICATION

310:657-23-1. Conditions for approval

The Commissioner shall issue or renew a certificate when the Commissioner finds that the Plan meets the requirements of the Act and OAC 310:657.

(1) Necessary medical and health services shall be provided by the Plan as guaranteed in the Plan's contracts with insurers and insureds and in the provider directory.
(A) These services shall be provided without bias for, or against, any type of provider.
(B) The Commissioner shall review services available considering employee population and characteristics, and locations and hours of providers.
(C) The Plan may offer necessary medical and health services directly, or may arrange services through contracts or

arrangements with providers, or may both offer and arrange services.

(2) All providers shall practice under licensing, certification or credentialing requirements of applicable laws, rules and professional standards.

(3) Medical and health services shall be available within the Plan's service area, considering the geographic location of the Plan and its providers, hours of operation, and population density.

(4) The Plan shall appoint a medical director qualified under the licensing or credentialing requirements of Oklahoma.

(5) The Plan shall maintain or arrange quality assurance, peer review, utilization review, dispute and grievance resolution, case management, and workplace health and safety consulting services.

(A) The Commissioner may consider the Plan's compliance with the standards of a recognized voluntary reviewing entity. Before accepting findings from another entity, the Commissioner shall affirm that the standards in use by the entity meet or exceed the standards set by the Commissioner.

(B) The Commissioner may approve a reasonable phase-in of these systems, based on the length of time the Plan has operated and the number of employees.

(C) The Commissioner shall consider a license, certificate or approval granted by an agency of the State of Oklahoma or the federal government.

(6) The persons responsible for the Plan have knowledge, skills and experience to operate the Plan.

(7) The Plan shall demonstrate financial responsibility and may reasonably be expected to meet its obligations to injured workers. The Commissioner shall consider the resources of the Plan's owner and may also consider the following:

(A) The financial soundness of any arrangements for paying providers, the accounting methods to control any funds paid to the Plan for providers, and the schedule of charges;

(B) Working capital; or

(C) Any agreement with providers for services.

310:657-23-2. Duration of certificate

The Commissioner may issue a certificate to a Plan for five (5) years. The Commissioner may specify conditions on an initial certificate which shall be satisfied before the Plan offers medical and health services to employees.

310:657-23-3. Certificate transfer

No certificate shall be issued to any person other than the person making application. A certificate shall not be transferred in whole or part to another person.

310:657-23-4. Denial of application

(a) An application for certification may be denied for one (1) or more of the following:

(1) Failure to meet any of the standards in the Act or OAC 310:657; or

(2) Failure to provide timely additional information required under OAC 310:657-21-2.

(b) Within ten (10) days after denial, the Department shall send written notice to the applicant. The notice of denial shall include a statement of the deficiencies on which denial was based and notice of the opportunity for hearing.

310:657-23-5. Appeals

Any party who disagrees with the Commissioner's decision to deny the application may request a hearing, or may appeal directly to district court as provided in the Administrative Procedures Act.

SUBCHAPTER 25. WITHDRAWAL OF A CERTIFICATE

310:657-25-1. Conditions to revoke or suspend

The Commissioner may revoke or suspend a certificate issued to a Plan, or take such other steps as appropriate, if the Plan:

(1) Is not in compliance with the Act or OAC 310:657;

(2) Violated its health service contracts;

(3) Is unable to fulfill its obligations under outstanding contracts for the benefit of employees;

(4) Attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices in advertising, merchandising or promoting towards providers, employees, insurers or insureds;

(5) Did not correct an impairment as required under OAC 310:657-15-6; or

(6) Knowingly uses or has knowingly used a provider who does not have a license, certificate or other authority to practice or furnish medical or health services.

310:657-25-2. Suspended certificate

(a) While a Plan's certificate is suspended, the Plan shall not, advertise or solicit additional business.

(b) The order suspending the certificate shall specify the period of suspension and conditions to be met for reinstatement.

310:657-25-3. Revoked certificate

(a) The Plan shall conduct no business except as may be essential to the orderly conclusion of its affairs when a Plan's certificate is revoked. The Commissioner may order such operations as needed to afford employees a practical opportunity for medical and health services.

(b) The Plan shall not apply for certification for at least two (2) years after a certificate is revoked. The Plan shall follow the procedures for an initial application specified at OAC 310:657-21 and shall submit evidence that the conditions causing the revocation have been corrected.

310:657-25-4. Person requesting action

An action to revoke or suspend a certificate may be requested by the Commissioner, the Department, or any other person.

SUBCHAPTER 27. REPORTS AND FILINGS

310:657-27-1. Annual reports

(a) By May 1 of each year, the Plan shall file:

(1) Financial statements which exhibit the Plan's financial condition on December 31 of the prior year and its income and expenses that year. These statements shall be prepared in accordance with accounting principles generally accepted in the United States of America. The Plan shall supplement the statements with any information requested by the Commissioner. Such statements shall be subscribed and sworn to by the president, secretary and other officers, with original signatures. A statement of financial condition shall include:

(A) A balance sheet; and

(B) Revenues and expenses;

(2) Summaries of the grievance and dispute resolution activities in the preceding year.

(b) By May 1 of each year, the Plan shall report:

(1) Service volume for the prior year;

(2) Results of the quality assurance procedures;

(3) Providers as of December 31 of the prior year; and

(4) Number of employees by zip code of residence or work site as of December 31 of the prior year.

310:657-27-2. Application form changes

Any material change in the information submitted in the application shall be submitted to the Department, including:

(1) The approved geographic service area or the organizational structure, including owner or operator;

(2) Provider agreements which may affect services available to employees, at least thirty (30) days before execution or termination of such agreements;
(3) Any request for changes in the approved quality assurance program, at least thirty (30) days before the proposed change;
(4) The chief executive officer or medical director, to be reported upon the termination or starting of employment, with biographical information for the new appointee;
(5) Ten (10) percent or more in provider hours of operation;
(6) Essential content in marketing materials, before issuance; and,
(7) Approval issued by a voluntary body or agency and relied upon by the Commissioner under OAC 310:657-23.

310:657-27-3. Commissioner review

The Commissioner shall have thirty (30) days after receipt to approve or deny proposed changes or required filings.

310:657-27-4. Maintenance of records

A Plan shall maintain records or information used to prepare required reports for at least five (5) years.

310:657-27-5. Documents as public record

All applications shall be available for public inspection in the Department offices during normal working hours. This applies to applications reviewed or under review by the Commissioner. All applications, filings and reports required under OAC 310:657 shall be public documents, except those containing trade secrets, privileged commercial or financial information, or confidential quality or utilization review materials. Financial information required under OAC 310:657-27 shall not be privileged information.

SUBCHAPTER 29. RESTRICTED AND PROHIBITED ACTS

310:657-29-1. Restricted provision of services

A Plan which has been granted a certificate to operate shall provide services only those persons who work, reside, or work and reside in its approved geographic service area.

310:657-29-2. Prohibited acts

(a) No person may operate a Plan in Oklahoma, nor use the phrase "workplace medical plan," nor imply that it is a workplace medical plan, unless that person first obtains a certificate.
(b) No Plan shall imply that certification qualifies the Plan to provide services except as authorized under the Act and OAC 310:657.
(c) A Plan, its employees and agents shall not:

(1) Pay claims reviewers based on reductions, unless the reductions are based on uniformly applied protocols designed to detect billing errors and duplicate charges;
(2) Compel an injured worker or a provider to:
(A) Accept less than the full settlement of a claim;
(B) File suit to obtain full settlement;
(C) Accept a lesser, interim figure as a premature final settlement; or
(3) Knowingly misrepresent reimbursement criteria and time frames to employees, a provider, an insurer, an insured, or their representatives.

310:657-29-3. Enforcement

If a person violates OAC 310:657-29, the Commissioner shall send written notice to the person to cease and desist the violation. If any person continues the violation, the Commissioner may seek an injunction to prohibit the continued offering of service.

SUBCHAPTER 31. TERMINATING AND CONTINUING SERVICES

310:657-31-1. Terminating services

(a) A Plan shall notify an insurer, an employer, providers, and open cases at least sixty (60) days before terminating services or not renewing the insurer's, employer's or provider's contract.
(b) Before terminating services, a plan shall make all necessary arrangements to provide the employer/payer with the medical records and all open or recent cases that have not previously been provided.
(c) An agreement between a provider and a Plan shall require the provider to notify the Plan at least sixty (60) days before termination of the agreement.

310:657-31-2. Bankruptcy strategy [REVOKED]

310:657-31-3. Dismissal from the Plan for cause

A Plan may request dismissal from the Plan of an employee for documented abusive, disruptive or threatening behavior which impairs the Plan's ability to provide services. Dismissal shall comply with the insurer's or insured's contract.

310:657-31-4. Notice

A Plan shall notify the Commissioner in writing at least ninety (90) days before any cessation of business. The Plan shall submit all notices and agreements before their release and effective dates.

SUBCHAPTER 33. POWERS OF A PLAN

310:657-33-1. Powers

The powers of a Plan include the following:

(1) Making transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates or between the Plan and its parent;

(2) Furnishing medical and health services through providers, associations or agents which contract with or are employed by the Plan;

(3) Contracting with any person for the performance on its behalf of functions such as marketing and administration; and

(4) Marketing of products with an insurer or insured, if the company offering each product is clearly identified.

310:657-33-2. Notice of exercise of powers

A Plan shall file notice and supporting information with the Department before the exercise of any power under OAC 310:657-33. The Commissioner shall disapprove an exercise of power if it will affect the Plan's financial soundness and endanger its ability to meet its obligations. The Commissioner shall have no more than thirty (30) days to act on the notice.

SUBCHAPTER 35. ENROLLMENT AND ELECTION PROCESS [REVOKED]

310:657-35-1. Obligations of Plan and insurer or insured [REVOKED]

310:657-35-2. Description of the notice and election form [REVOKED]