Ohio Revised Code

Section 1751.80 Implementing utilization review programs.

Effective: October 1, 1998
Legislation: House Bill 361 - 122nd General Assembly

The utilization review program of a health insuring corporation shall be implemented in accordance with all of the following:

(A) The program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health insuring corporation may develop its own clinical review criteria or may purchase or license such criteria from qualified vendors. A health insuring corporation shall make its clinical review rationale available upon request to authorized government agencies. The rationale made available to authorized government agencies is confidential and is not a public record as defined in section 149.43 of the Revised Code.

(B) Qualified providers shall administer the program and oversee review determinations. A clinical peer in the same, or in a similar, specialty as typically manages the medical condition, procedure, or treatment under review shall evaluate the clinical appropriateness of adverse determinations that are the subject of an appeal.

(C) The health insuring corporation shall issue utilization review determinations in a timely manner pursuant to the requirements of sections 1751.81 and 1751.82 of the Revised Code and the enrollee grievance requirements. The health insuring corporation shall obtain information required to make a utilization review determination, including pertinent clinical information, and shall establish a process to ensure that utilization reviewers apply clinical review criteria consistently.

(D) If the health insuring corporation delegates any utilization review activities to a utilization review organization, the health insuring corporation shall maintain adequate oversight, including a process by which the health insuring corporation evaluates the performance of the organization, and shall maintain copies of both of the following:

(1) A written description of the organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the organization's program by the health insuring corporation.

(E) The health insuring corporation or its designee utilization review organization shall provide enrollees and participating providers with access to its review staff by means of a toll-free telephone number or collect-call telephone line.

(F) When conducting prospective or concurrent review, the health insuring corporation or its designee utilization review organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of health care services.

(G) Compensation to persons providing utilization review services for the health insuring corporation shall not contain incentives, direct or indirect, for them to make inappropriate review decisions.