Ohio Revised Code

Section 1751.81 Maintaining written procedures for determining whether requested service is covered.

Effective: May 1, 2000
Legislation: House Bill 4 - 123rd General Assembly

(A) As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required

(B) A health insuring corporation shall maintain written procedures for determining whether a requested service is a service covered under the terms of an enrollee's policy, contract, or agreement, making utilization review determinations, and notifying enrollees, participating providers, and health care facilities acting on behalf of enrollees, of its determinations.

(C) For prospective review determinations, a health insuring corporation shall make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination.

(1) In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information.

(1) In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation shall notify the provider or health care facility rendering the health care

service by telephone or facsimile within one business day after making the certification.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee shall be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.

(E) For retrospective review determinations, a health insuring corporation shall make the determination within thirty business days after receiving all necessary information.

(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.

(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

(F)(1) The time frames set forth in divisions (C), (D), and (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

(2) An enrollee, an authorized person, the enrollee's provider, or the health care facility rendering health care service to an enrollee may proceed with a request for an internal review pursuant to section 1751.83 of the Revised Code if a health insuring corporation fails to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section. The enrollee may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the enrollee.

The health insuring corporation's failure to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section shall be deemed to be an adverse determination by the health insuring corporation for the purpose of initiating an internal review.

(G) A written notification of an adverse determination shall include the principal reason or reasons for the determination, instructions for initiating a reconsideration of the determination under section 1751.82 of the Revised Code or an internal review under section 1751.83 of the Revised Code, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation shall provide the clinical rationale for an adverse determination in writing to any party who received notice of the adverse determination and who follows the instructions for a request.

(H)(1) A health insuring corporation shall have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review.

(2) A health insuring corporation shall not use unreasonable requests for information to delay making a determination.

(3) If the health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification. An enrollee need not be granted an internal review pursuant to section 1751.83 of the Revised Code based on a health insuring corporation's failure to make a timely determination, if the health insuring corporation's delay in making a determination and notification is caused by the failure of a health care facility, provider, or enrollee to release all necessary information, in which case the health insuring corporation shall notify the enrollee in writing of the reason for the delay.