Ohio Revised Code

Section 3902.52 Out-of-network care arbitration.

Effective: April 12, 2021
Legislation: House Bill 388 - 133rd General Assembly

(A)(1) If a negotiation undertaken pursuant to division (B)(2) of section 3902.51 of the Revised Code has not successfully concluded within thirty days, or if both parties agree that they are at an impasse, the provider, facility, emergency facility, or ambulance may send a request for arbitration to the superintendent of insurance and shall notify the health plan issuer of its request. To be eligible for arbitration, both of the following must apply:

(a) The service in question was provided not more than one year prior to the request.

(b) The billed amount exceeds seven hundred fifty dollars, except as provided in division (A)(2)(b) of this section.

(2)(a) In seeking arbitration, a provider, facility, emergency facility, or ambulance may bundle up to fifteen claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances. Any bundled claims shall be for services using the same coding set and providers of the same license type.

(b) A claim that is bundled with other claims may be seven hundred fifty dollars or less so long as the sum of the bundled claims is greater than seven hundred fifty dollars.

(B) If arbitration is requested under division (A) of this section, each party shall submit its final offer to the arbitrator. The parties also may submit, and the arbitrator may consider, evidence that relates to the factors described in division (C) of this section if the evidence is in a form that can be verified and authenticated.

(C) An arbitrator shall consider all of the following factors in rendering a decision:

(1) The in-network rates that other health benefit plans reimburse, and have reimbursed, that particular provider, facility, emergency facility, or ambulance for the service in question, including

the factors that went into those rates such as guaranteed patient volume or availability of providers in the provider's, facility's, emergency facility's, or ambulance's geographic area;

(2) The in-network rates that the health benefit plan reimburses, or has reimbursed, other providers, facilities, emergency facilities, or ambulances for the service in question in that particular geographic area, including the factors that went into those rates such as guaranteed patient volume or availability of providers in that particular geographic area;

(3) If the health plan issuer and the provider, facility, emergency facility, or ambulance have had a contractual relationship in the previous six years, any in-network reimbursement rates previously agreed upon between the issuer and the provider, facility, emergency facility, or ambulance;

(4) The results of, or any documents submitted in the course of, a previous arbitration between the parties conducted under this section that the arbitrator considers relevant in rendering a decision.

(D) After considering the evidence submitted by the parties pursuant to division (B) of this section and the criteria described in division (C) of this section, the arbitrator shall issue a decision that awards the final offer of either party that best reflects a fair reimbursement rate based upon the factors considered under division (C) of this section.

(E) The nonprevailing party shall pay seventy per cent of the arbitrator's fees, and the prevailing party shall pay thirty per cent.

(F) A final arbitration decision shall be binding except as to other remedies available at law.

(G) Documents and other evidence submitted to an arbitrator under this section are confidential, not public records for the purposes of section 149.43 of the Revised Code, and shall not be released except as authorized pursuant to this division. If release of the evidence is required pursuant to a court order, the arbitrator shall release the evidence pursuant to the court order but shall redact from the evidence released information that constitutes intellectual property, trade secrets, or information requiring redaction pursuant to a rule adopted by the superintendent of insurance.

(H) As used in this section, "provider" includes a practice of providers to the extent permitted by

rules adopted by the superintendent of insurance under division (D) of section 3902.54 of the Revised Code including but not limited to rules adopted regarding the maximum number of providers in a practice.