Ohio Revised Code

Section 3999.22 Health insurance referrals - prohibited activities - exceptions.

Effective: March 22, 1999
Legislation: House Bill 698 - 122nd General Assembly

(A) As used in this section:

(1) "Claim" means any attempt to cause a health care insurer to make payment of a health care benefit.

(2) "Health care benefit" means the right under a contract or a certificate or policy of insurance to have a payment made by a health care insurer for a specified health care service.

(3) "Health care insurer" means any person that is authorized to do the business of sickness and accident insurance, any health insuring corporation, and any legal entity that is self-insured and provides health care benefits to its employees or members.

(B) No person shall knowingly solicit, offer, pay, or receive any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual for the furnishing of health care services or goods for which whole or partial reimbursement is or may be made by a health care insurer, except as authorized by the health care or health insurance contract, policy, or plan. This division does not apply to any of the following:

(1) Deductibles, copayments, or similar amounts owed by the person covered by the health care or health insurance contract, policy, or plan;

(2) Discounts or similar reductions in prices;

(3) Any amount paid within a bona fide legal entity, or within legal entities under common ownership or control, including any amount paid to an employee in a bona fide employment relationship;

(4) Any amount paid as part of a bona fide lease, management, or other business contract.

(C) Nothing in this section shall be construed to apply to any of the following:

(1) A provider who provides goods or services requested by an individual that are not covered by the individual's health care or health insurance contract, policy, or plan;

(2) A provider who, in good faith, provides goods or services ordered by another health care provider;

(3) A provider who, in good faith, resubmits a claim previously submitted that has not been paid or denied within thirty days of the original submission, if the provider notifies the payor or returns any duplicate payment within sixty days after receipt of the duplicate payment;

(4) A provider who, in good faith, makes a diagnosis that differs from the interpretation of a diagnosis reached by a health care insurer in the payment of claims.

(D) Whoever violates this section is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.