# Ohio Revised Code

## Section 1751.77 Utilization review, internal and external review procedure definitions.

Effective: October 17, 2019
Legislation: House Bill 166 - 133rd General Assembly

As used in sections 1751.77 to 1751.87 of the Revised Code, unless otherwise specifically provided or as otherwise required pursuant to applicable federal law or regulations:

(A) "Adverse determination" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, the health care service does not meet the requirements for benefit payment under the health insuring corporation's policy, contract, or agreement, and coverage is therefore denied, reduced, or terminated.

(B) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(C) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of an enrollee with respect to health care decisions.

(D) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other specified health conditions.

(E) "Certification" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, the health care service satisfies the requirements for benefit payment under the health insuring corporation's policy, contract, or agreement.

(F) "Clinical peer" means a physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a provider who is not a physician,

"clinical peer" means either a physician or a provider holding the same license as the provider who provided the health care services.

(G) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insuring corporation to determine the necessity and appropriateness of health care services.

(H) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(I) "Discharge planning" means the formal process for determining, prior to a patient's discharge from a health care facility, the coordination and management of the care that the patient is to receive following discharge from a health care facility.

(J) "Participating provider" means a provider or health care facility that, under a contract with a health insuring corporation or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insuring corporation.

(K) "Physician" means a provider who holds a license issued under Chapter 4731. of the Revised Code authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license from another state.

(L) "Prospective review" means utilization review that is conducted prior to an admission or a course of treatment.

(M) "Retrospective review" means utilization review of medical necessity that is conducted after health care services have been provided to a patient. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

(N) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for proposed health care

services to assess the clinical necessity and appropriateness of the proposed health care services.

(O) "Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(P) "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans.