Ohio Revised Code

Section 3702.304 Variances from written transfer agreements.

Effective: September 30, 2021
Legislation: House Bill 110

(A)(1) The director of health may grant a variance from the written transfer agreement requirement of section 3702.303 of the Revised Code if the ambulatory surgical facility submits to the director a complete variance application, prescribed by the director, and the director determines after reviewing the application that the facility is capable of achieving the purpose of a written transfer agreement in the absence of one. The director's determination is final.

(2) Not later than sixty days after receiving a variance application from an ambulatory surgical facility, the director shall grant or deny the variance. A variance application that has not been approved within sixty days is considered denied.

(B) A variance application is complete for purposes of division (A)(1) of this section if it contains or includes as attachments all of the following:

(1) A statement explaining why application of the requirement would cause the facility undue hardship and why the variance will not jeopardize the health and safety of any patient;

(2) A letter, contract, or memorandum of understanding signed by the facility and one or more consulting physicians who have admitting privileges at a minimum of one local hospital that is located within a twenty-five mile radius of the facility, memorializing the physician or physicians' agreement to provide back-up coverage when medical care beyond the level the facility can provide is necessary;

(3) For each consulting physician described in division (B)(2) of this section:

(a) A signed statement in which the physician attests to all of the following:

(i) The physician actively practices clinical medicine within a twenty-five mile radius of the facility.

(ii) The physician is familiar with the facility and its operations.

(iii) The physician agrees to provide notice to the facility of any changes in the physician's ability to provide back-up coverage.

(b) The estimated travel time from the physician's main residence or office to each local hospital where the physician has admitting privileges;

(c) Written verification that the facility has a record of the name, telephone numbers, and practice specialties of the physician;

(d) Written verification from the state medical board that the physician possesses a valid license to practice medicine and surgery or osteopathic medicine and surgery issued under Chapter 4731. of the Revised Code;

(e) Documented verification that each hospital at which the physician has admitting privileges has been informed in writing by the physician that the physician is a consulting physician for the ambulatory surgical facility and has agreed to provide back-up coverage for the facility when medical care beyond the care the facility can provide is necessary.

(4) A copy of the facility's operating procedures or protocols that, at a minimum, do all of the following:

(a) Address how back-up coverage by consulting physicians is to occur, including how back-up coverage is to occur when consulting physicians are temporarily unavailable;

(b) Specify that each consulting physician is required to notify the facility, without delay, when the physician is unable to expeditiously admit patients to a local hospital and provide for continuity of patient care;

(c) Specify that a patient's medical record maintained by the facility must be transferred contemporaneously with the patient when the patient is transferred from the facility to a hospital.

(5) Any other information the director considers necessary.

(C) The director's decision to grant, refuse, or rescind a variance is final.

(D) The director shall consider each application for a variance independently without regard to any decision the director may have made on a prior occasion to grant or deny a variance to that ambulatory surgical facility or any other facility.