Ohio Revised Code

Section 3922.01 Definitions.

Effective: September 6, 2012
Legislation: House Bill 341 - 129th General Assembly

As used in this chapter:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a health care service is not a covered benefit;

(d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.

(C) "Authorized representative" means an individual who represents a covered person in an internal

appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(G) "Emergency medical condition" has the same meaning as in section 1753.28 of the Revised Code.

(H) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(I) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence, based on a systematic review of the relevant research, in making decisions about the care of individuals.

(J) "Facility" means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(K) "Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

(L) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, as described in section 3923.37 of the Revised Code, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(M) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

(N) "Health care provider" or "provider" means a health care professional or facility.

(O) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(P) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(Q) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to all of the following:

(1) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(2) The provision of health care services or health-related benefits to a covered person;

(3) Payment for the provision of health care services to or for a covered person.

(R) "Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations pursuant to section 3922.13 of the Revised Code.

(S) "Medical or scientific evidence" means evidence found in any of the following sources:

(1) Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;

(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;

(4) The following standard reference compendia:

(a) The American hospital formulary service drug information;

(b) Drug facts and comparisons;

(c) The American dental association accepted dental therapeutics;

(d) The United States pharmacopoeia drug information.

(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:

(a) The federal agency for health care research and quality;

(b) The national institutes of health;

(c) The national cancer institute;

(d) The national academy of sciences;

(e) The centers for medicare and medicaid services;

(f) The federal food and drug administration;

(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.

(6) Any other medical or scientific evidence that is comparable.

(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.

(U) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.

(V) "Rescind" means to retroactively cancel or discontinue coverage. "Rescind" does not include canceling or discontinuing coverage that only has a prospective effect or canceling or discontinuing coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(W) "Retrospective review" means a review conducted after services have been provided to a covered person.

(X) "Superintendent" means the superintendent of insurance.

(Y) "Utilization review" has the same meaning as in section 1751.77 of the Revised Code.

(Z) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.