As Introduced

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Senators Oelslager, Cafaro

Cosponsors: Senators Seitz, Lehner, Gillmor, Patton, Manning, Tavares, Grendell, Sawyer, Wagoner

A B I L L

To amend sections 1753.16, 3901.381, 3901.385, 3901.388, and 3963.04 of the Revised Code to make changes to the law regarding preapproval of and payment for health care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1753.16, 3901.381, 3901.385, 3901.388, and 3963.04 of the Revised Code be amended to read as follows:

Sec. 1753.16. A health insuring corporation or utilization review organization that authorizes in writing a proposed admission, treatment, or health care service by a participating provider ~~based upon the complete and accurate submission of all necessary information relative to an eligible enrollee~~ shall not retroactively deny this authorization ~~if the provider renders the health care service in good faith and pursuant to~~ during or after the performance of the service unless the authorization ~~and all of the terms and conditions of the provider's contract with~~ was based upon fraudulent information provided to the health insuring corporation or utilization review organization by the enrollee or

provider.

Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim within fifteen days after receipt of the claim or, if the provider submits the claim by some method other than electronically pursuant to an agreement entered into with the third-party payer under section 3901.382 of the Revised Code, not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim, or forty-five days after receipt of the claim if the provider submitted the claim by some method other than electronically pursuant to an agreement entered into with the third-party payer under section 3901.382 of the Revised Code. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of

premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification.

Not later than fifteen days after receipt of the claim, or thirty days after receipt of the claim if the provider submitted the claim by some method other than electronically pursuant to an agreement entered into with the third-party payer under section 3901.382 of the Revised Code, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer.

The number of days that elapse between the third-party payer's last request for supporting documentation within the fifteen- or thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period ~~of not more than forty-five days~~ for payment or denial of a claim under division (B)(2)(a) of this section. Except as provided in division (B)(2)(b) of this section, if the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the

request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period ~~of not more than forty-five days~~ for payment or denial of a claim under division (B)(2)(a) of this section.

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period ~~of not more than forty-five days~~ for payment or denial of a claim under division (B)(2)(a) of this section.

(c) When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(d) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format.

Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-9 code in

effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.

It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.

(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the

claim was mailed, unless it can be proven otherwise.

(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.

(F) A third-party payer shall transmit electronically any payment with respect to claims that the third-party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

Sec. 3901.385. (A) A third-party payer shall not do either of the following:

~~(A)~~(1) Engage in any business practice that unfairly or unnecessarily delays the processing of a claim or the payment of any amount due for health care services rendered by a provider to a beneficiary;

~~(B)~~(2) Refuse to process or pay within the time periods specified in section 3901.381 of the Revised Code a claim submitted by a provider on the grounds the beneficiary has not

been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.

(B) No third-party payer that agrees in writing to cover a health care service before the service is rendered shall deny payment for that service during or after the performance of the service unless the agreement to cover the service was based upon fraudulent information provided to the third-party payer by the beneficiary or provider.

(C) Each third-party payer that requires or allows a beneficiary or provider to give notification of, or to obtain authorization or certification for, a health care service before the service is rendered shall do all of the following:

(1) Make current prior authorization or precertification requirements and restrictions readily accessible to beneficiaries, providers, and the general public on the third-party payer's web site;

(2) Update the third-party payer's web site to reflect any new or amended prior authorization or precertification requirement and restriction at least sixty days prior to the effective date of the change;

(3) Provide written notice to providers of any new or amended prior authorization or precertification requirement and restriction at least sixty days prior to the effective date of the change;

(4) Establish and maintain a web-based system through which beneficiaries and providers may provide that prenotification or obtain the prior authorization or precertification;

(5) Make statistics that detail the number of approvals and denials of prior authorization or precertification of claims

readily accessible to beneficiaries, providers, and the general public on the third-party payer's web site in the following categories:

(a) Physician specialty;

(b) Medication or diagnostic tests and procedures;

(c) Indication offered in the request;

(d) Reason for denial.

(D) The information concerning current prior authorization or precertification requirements and restrictions that the third-party payer posts on its web site under division (C)(1) of this section shall satisfy all of the following requirements:

(1) The information shall include written clinical criteria.

(2) The information shall be described in detail.

(3) The information shall be described in easily understandable language.

Sec. 3901.388. (A) ~~A~~ (1) Except as provided in division (A)(2) of this section, a payment made by a third-party payer to a provider in accordance with sections 3901.381 to 3901.386 of the Revised Code shall be considered final ~~two years~~ one hundred eighty days after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

(2) If the terms of a contract between a third-party payer and a provider limit the period of time that the provider has to submit claims for payment to a period of less than one hundred eighty days, any payment made by the third-party payer to that provider in accordance with sections 3901.381 to 3901.386 of the Revised Code shall be considered final upon the expiration of that same amount of time after payment is made. After that date, the

amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

(B) A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated ~~not later than two years after~~ before the payment ~~was made to the provider~~ is considered final under division (A) of this section. The third-party payer shall inform the provider of its determination of overpayment by providing notice in accordance with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.

When a provider has failed to make a timely response to the notice of the third-party payer's determination of overpayment, the third-party payer may recover the overpayment by deducting the amount of the overpayment from other payments the third-party payer owes the provider or by taking action pursuant to any other remedy available under the Revised Code. When a provider elects not to appeal a determination of overpayment or appeals the determination but the appeal is not upheld, the third-party payer shall permit a provider to repay the amount by making one or more direct payments to the third-party payer or by having the amount deducted from other payments the third-party payer owes the provider.

(C) The notice of overpayment a third-party payer is required to give a provider under division (B) of this section shall be made in writing and shall specify all of the following:

(1) The full name of the beneficiary who received the health care services for which overpayment was made;

(2) The date or dates the services were provided;

(3) The amount of the overpayment;

(4) The claim number or other pertinent numbers;

(5) A detailed explanation of basis for the third-party payer's determination of overpayment;

(6) The method in which payment was made, including, for tracking purposes, the date of payment and, if applicable, the check number;

(7) That the provider may appeal the third-party payer's determination of overpayment, if the provider responds to the notice within thirty days;

(8) The method by which recovery of the overpayment would be made, if recovery proceeds under division (B) of this section.

(D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

Sec. 3963.04. (A)(1) If an amendment to a health care contract is not a material amendment, the contracting entity shall provide the participating provider notice of the amendment at least fifteen days prior to the effective date of the amendment. The contracting entity shall provide all other notices to the participating provider pursuant to the health care contract.

(2) A material amendment to a health care contract shall occur only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than ninety days prior to the effective date of the material amendment. The notice shall be conspicuously entitled "Notice of Material Amendment to Contract."

(3) If within fifteen days after receiving the material

amendment and notice described in division (A)(2) of this section, the participating provider objects in writing to the material amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than sixty days prior to the effective date of the material amendment.

(4) If the participating provider does not object to the material amendment in the manner described in division (A)(3) of this section, the material amendment shall be effective as specified in the notice described in division (A)(2) of this section.

(5) If the participating provider objects to the material amendment in the manner described in division (A)(3) of this section, and there is no resolution, and neither party terminates the health care contract, the material amendment shall not become part of the existing health care contract.

(B)(1) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee, if the material amendment of a health care contract is required by state or federal law, rule, or regulation, or if the provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date than otherwise required by division (A)(2) of this section.

(2) This section does not apply under any of the following circumstances:

(a) The participating provider's payment or compensation is based on the current medicaid or medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.

(b) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any

service code, procedure code, or reporting code, or a pricing change is made by any third party source.

For purposes of division (B)(2)(b) of this section:

(i) "Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

(ii) "Third party source" means the American medical association, American dental association, the centers for medicare and medicaid services, the national center for health statistics, the department of health and human services office of the inspector general, the Ohio department of insurance, or the Ohio department of job and family services.

(C) Notwithstanding divisions (A) and (B) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in this section shall be construed to require the renegotiation of a health care contract that is in existence before ~~the effective date of this section~~ June 25, 2008, until the time that the contract is renewed or materially amended.

Section 2. That existing sections 1753.16, 3901.381, 3901.385, 3901.388, and 3963.04 of the Revised Code are hereby repealed.