Ohio Legislative Service Commission

Bill Analysis

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S.B. 136

129th General Assembly
(As introduced)

Sens. Oelslager and Cafaro, Seitz, Lehner, Gillmor, Patton, Manning, Tavares, Grendell, Sawyer, Wagoner

BILL SUMMARY

- Prohibits health insuring corporations, utilization review organizations, and third-party payers from retroactively denying payment for a service after the performance of the service, if the health insuring corporation, utilization review organization, or third-party payer had, agreed, in writing, to provide coverage for the service.
- Revises third-party payer payment deadlines to account for electronic and non-electronic submission of claims.
- Requires third-party payers that make providers receive authorization or certification prior to providing a health service meet specified requirements.
- Reduces the date after which a payment made by a third-party payer is considered no longer subject to adjustment to 180 days after the payment is made, as opposed to two years under current law.
- Expressly specifies that, for those contracts between a health care provider and a contracting entity, material amendment to the contract is not made if the participating provider objects.

CONTENT AND OPERATION

Retroactive denials

Health insuring corporations and utilization review organizations

The bill prohibits health insuring corporations and utilization review organizations from denying payment for a service during or after the performance of

the service if the health insuring corporation or utilization review organization had, prior to the performance of the service, agreed, in writing, to provide coverage for the service. An exception to this prohibition is made in the case of the agreement to cover the service being based on fraudulent information provided by the enrollee or the provider.[1]

The prohibition existing under current law differs in all of the following ways:

- The agreement is not required to be in writing.
- The provider must have rendered the service in good faith.
- The service must be provided in accordance with the covered person's contract with the health insuring corporation.
- The agreement must have been based on the complete and accurate submission of all necessary information relative to the covered person.[2]

Third-party payers

The bill prohibits third-party payers (which can include insurance companies, health insuring corporations, labor organizations, and employers) from denying payment for a service during or after the performance of the service, if the third-party payer had, prior to the performance of the service, agreed, in writing, to provide coverage for the service. An exception to this prohibition is made in the case of the agreement to cover the service being based on fraudulent information provided by the beneficiary or provider.[3]

Third-party payer payment deadlines

The bill revises third-party payer payment deadlines to account for electronic and non-electronic submission of claims. The bill requires third-party payers to pay or deny a claim within 15 days after receiving the claim, as opposed to 30 days under current law, if the claim is submitted electronically. If a provider submits the claim by some method other than electronically pursuant to an agreement between the third-party payer and the provider, then the deadline is 30 days.

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[1] R.C. 1753.16.

[2] R.C. 1753.16.

[3] R.C. 3901.385(B).

In situations where additional documentation is required, the third-party payer has 30 days after receiving the claim, as opposed to 45 days under current law, to deny or pay a claim submitted by electronic means, or 45 days in the case of a claim submitted by non-electronic means pursuant to an agreement. A third-party provider must submit a request for such additional documentation within 15 days, as opposed to 30 days under current law, of the receipt of a claim if the claim was submitted via electronic means, or 30 days if the claim was submitted via non-electronic means.[4]

Third-party payers requiring prior authorization of services

Third-party payers that require notification or authorization or certification before a health service can be performed, are required to do all of the following under the bill:

- Make current prior authorization or precertification requirements readily accessible on the third-party payer's web site;
- Update the web site to reflect changes to prior authorization or precertification requirements at least 60 days prior to the effective date of the change;
- Provide written notice to providers of changes to prior authorization or precertification requirements at least 60 days prior to the effective date of the change;
- Establish and maintain a web-based system through which beneficiaries and providers may provide that prenotification or obtain necessary prior authorization or precertification.

The posted prior authorization or precertification requirements and restrictions must also meet all of the following:

- Include written clinical criteria;
- Be described in detail;
- Be described in easily understandable language.[5]

In addition to the requirements listed above, the third-party payer must also make statistics that detail the number of approvals and denials of prior authorization or

[4] R.C. 3901.381.

[5] R.C. 3901.385(C)(1) to (4) and (D).

precertification claims readily accessible on the third-party payer's web site in the following categories:

- Physician specialty;
- Medication or diagnostic tests and procedures;
- Indication offered in the request;
- Reason for denial.[6]

Alternations to payments made by third-party payers

The bill reduces the date after which a payment made by a third-party payer is considered final to 180 days after the payment is made, as opposed to two years under current law.[7] After that date, the amount of payment is not subject to adjustment. An exception to this deadline is made in those cases where a provider has less than 180 days to submit a claim for payment to a third-party payer, subject to the terms of a contract between a provider and a third-party payer. In those cases, the bill considers a payment final upon the expiration of the time period specified in the contract, from the date of the payment being made. An additional exception is made to this second deadline in the case of fraud by the provider.[8]

Material amendments to health care contracts

Under continuing law, a contracting entity is required to give a provider prior written notice of a material amendment to the health care contract. The health care provider has 15 days within which to object to the amendment. If the provider does not timely object, the amendment becomes effective. The bill expressly provides that if the health care provider objects, there is no resolution of the conflict, and neither party terminates the contract, the material amendment does not become part of the existing contract.[9]

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[6] R.C. 3901.385(C)(5).

[7] R.C. 3901.388(A).

[8] R.C. 3901.388(B).

[9] R.C. 3963.04(A)(5).

HISTORY

ACTION	DATE
Introduced	03-30-11

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