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Bill Analysis

Version: As Introduced

Primary Sponsors: Rep. Manchester

Logan Briggs, Attorney

SUMMARY

- Requires health insuring corporations and sickness and accident insurers (collectively "health insurers") to conduct utilization reviews of claims for emergency services prior to denying or reducing payment for such claims.
- Specifies the standards and procedures for emergency services utilization reviews.
- Prohibits health insurers from reducing or denying claims for emergency services solely based on a diagnosis code or impression, current Internal Classification of Diseases (ICD) code, or select procedure code.
- Prohibits health insurers from reducing or denying claims for emergency services due to the absence of an emergency medical condition if a prudent layperson would have reasonably expected the presence of an emergency medical condition.
- Requires health insurers to inform enrollees that they are not required to self-diagnose.
- Revises the scope of existing requirements that health insurers cover emergency services by expanding the definition of "emergency medical condition" to include physical and mental health conditions.

DETAILED ANALYSIS

Utilization review

Requirement to conduct review

The bill prohibits health insuring corporations and sickness and accident insurers (collectively "health insurers") from doing either of the following with respect to a claim for emergency services:

- Reducing or denying a claim for reimbursement for emergency services based solely on a diagnosis code or impression, current Internal Classification of Diseases ("ICD") code,

or select procedure code relating to the enrollee's condition included on a form submitted to the health insurer by a provider for reimbursement of a claim;[1]

- Reducing or denying reimbursement for an emergency service based on a determination of the absence of an emergency medical condition if a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of an emergency medical condition.[2]

The bill also requires health insurers to perform an emergency services utilization review before reducing or denying a claim for emergency services. An emergency services utilization review is a review of a claim related to emergency services for the purpose of determining whether the claim relates to an emergency condition or whether a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of an emergency medical condition.[3]

The utilization review must include a review of the patient's entire medical record, including all of the following:

- The complaint in question including presenting symptoms;
- The patient's medical history (repeated utilization of the emergency department may be considered);
- The patient's diagnostic testing;
- Whether a prudent layperson would reasonably presume the presence of an emergency medical condition.[4]

None of the above requirements applies when a health insurer reduces reimbursement based on a contractually agreed upon reimbursement rate.[5]

Physician reviewers

Only a physician in good standing with the State Medical Board of Ohio may conduct a utilization review. The physician must also meet all of the following criteria:

- The physician must be certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine;
- The physician must not be directly or indirectly hired by the health insurer except for the purpose of the utilization review;

[1] R.C. 1753.28(E)(1) and 3923.65(E)(1).

[2] R.C. 1753.28(E)(2) and 3923.65(E)(2).

[3] R.C. 1753.28(E)(3) and 3923.65(E)(3); R.C. 1753.28(A)(5).

[4] R.C. 1753.28(G) and 3923.65(G).

[5] R.C. 1753.28(H) and 3923.65(H).

- The physician must have substantial professional experience providing emergency medical services in an acute care hospital emergency department within the prior two years.[6]

Review procedures

If a health insurer requests records related to a potential denial or reimbursement reduction of a person's benefits when emergency services were furnished, the bill requires a provider of emergency services to respond to the health insurer in a timely manner.[7]

If an independent emergency physician reviewer determines that the reimbursement or any part of the claim should be denied, reduced or paid at a lower level of emergency service, or as a nonemergency service, or otherwise, the bill requires the reviewer to explain in writing the reason for the reduction or denial of reimbursement. The explanation for the reduction or denial and the reviewer's name, date, signature, and supporting evidence must be provided in writing to the insured person and the provider.[8]

The bill states that it must not be construed as exempting a health insurer from the Ohio Prompt Pay Law.[9]

Notice and disclosure requirements

Continuing law requires health insurers to inform enrollees of the scope and coverage of emergency services, the appropriate use of emergency services, cost sharing requirements or copayments for emergency services, and the procedures for obtaining emergency and other medical services. The bill also requires a health insurer to inform its enrollees that they are not required to self-diagnose.[10]

Coverage for mental health emergencies

Continuing law requires health insuring corporations and sickness and accident insurers to cover emergency services for enrollees with emergency medical conditions without regard to the day or time the emergency services are rendered or to whether the enrollee, the hospital's emergency department where the services are rendered, or an emergency physician treating the enrollee obtained prior authorization for the emergency services.[11] The bill specifies that these requirements apply respecting both physical and mental health emergencies. Current law

[6] R.C. 1753.28(F) and 3923.65(F).

[7] R.C. 1753.28(I) and 3923.65(I).

[8] R.C. 1753.28(J) and 3923.65(J).

[9] R.C. 1753.28(K) and 3923.65(K) and R.C. 3901.381 to 3901.3814, not in the bill.

[10] R.C. 1753.28(D) and 1753.28(D)(5).

[11] R.C. 1753.28(B) and 3923.65(B).

applies the requirements to "medical emergencies," which might include mental health emergencies, but is open to interpretation.[12]

HISTORY

Action	Date
Introduced	03-09-23

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[12] R.C. 1753.28(A)(1).