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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Manchester and Upchurch

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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 denying claims for emergency services solely due to a final diagnosis that the medical condition was not emergency in nature.
- Requires health insurers to make certain disclosures to enrollees regarding emergency care.
- Makes violations of the bill's provisions an unfair and deceptive practice in the business of insurance.
- Clarifies the scope of emergency services that health insurers must offer as it relates to a pregnant woman having contractions.
- Revises the scope of existing requirements that health insurers cover emergency services by amending the definitions of both "emergency medical condition" and "emergency services."

DETAILED ANALYSIS

Utilization review

Requirement to conduct review

The bill requires health insuring corporations and sickness and accident insurers (collectively "health insurers") to conduct an independent emergency physician review (an emergency services utilization review conducted by an emergency physician) before doing any of the following with respect to a claim for emergency services:

- Denying benefits;
- Selecting a Current Procedural Terminology code (CPT code) of lesser acuity than what was billed by the provider;
- Reducing reimbursement for an emergency service based on a determination of the absence of an emergency medical condition;
- Determining that medical necessity was not present and therefore reimbursing at a lower level of care or as a nonemergency procedure.[1]

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 and includes a determination includes a determination as to whether or not there was medical necessity for the level of services required for the evaluation, treatment, or both of the emergency condition.[2]

The utilization review must include, at minimum, a review of the following related to the emergency service:

- The person's medical record, including the nature of the presenting problems or symptoms;
- The person's patient history;
- The exam and medical decision making.[3]

In addition to review of the above information relating specifically to the emergency service, the utilization review must also include a review of the patient's entire medical record, including all of the following:

- The complaint in question;
- The patient's medical history;
- The patient's diagnostic testing;
- The medical decision making history of the physician in question.[4]

None of the above requirements applies when a health insurer reduces reimbursement based on a contractually agreed upon adjustment for health care services.[5] In no case,

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

[2] R.C. 1753.28(A)(4) and 3923.65(A).

[3] R.C. 1753.28(H)(2) and 3923.65(H)(2).

[4] R.C. 1753.28(F)(1) and 3923.65(F)(1).

[5] R.C. 1753.28(H)(3) and 3923.65(H)(3).

however, may a health insurer reduce or deny a claim based solely on a final diagnosis or impression, International Classification of Diseases code (ICD code), or select procedure code.[6]

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 board 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;
- The physician must have substantial professional experience providing emergency medical services in an acute care hospital emergency department within the prior two years.[7]

The bill specifies that for utilization reviewers operating in Ohio, providing a review is considered the practice of medicine and is subject to the oversight and review of the State Medical Board of Ohio.[8]

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.[9]

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.[10]

The bill states that it must not be construed as exempting a health insurer from the Ohio Prompt Pay Law.[11]

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

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

[8] R.C. 1753.28(F)(2) and 3923.65(F)(2).

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

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

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

Notice and disclosure requirements

The bill requires health insurers to inform their enrollees at the time of enrollment and not less than annually thereafter that emergency care is a covered benefit along with the legal definition of "emergency medical condition" (see "**Scope and definitions**" below).[12] In addition, a health insurer must clearly educate its enrollees on the fact that, if an enrollee believes they may have an emergency medical condition, the health insurer will cover any emergency services even if, after the emergency evaluation, no emergency is found. The bill also requires a health insurer to inform its enrollees that they are not required to self-diagnose. Under the bill, all information provided to enrollees, including advertisements, websites, enrollee advice, enrollee correspondence, and language in the explanation of benefits, must be consistent with the bill and must not be false or misleading.[13]

Other provisions

The bill prohibits a health insurer from discouraging appropriate use of the emergency department. It also requires a health insurer to educate enrollees as to the appropriate site of service based upon symptoms and availability of alternative sites of care.[14]

Penalties

Repeated violations of the bill's requirements is considered an unfair and deceptive practice in the business of insurance, permitting the Superintendent of Insurance to impose a variety of sanctions on the violator. Possible sanctions include suspending or revoking the insurer's license, ordering the insurer to make restitution, and imposing a civil penalty.[15]

Existing requirement that emergency services be covered

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.[16] By amending the definitions of both "emergency medical condition" and "emergency services," described below, the bill revises the scope of these requirements.

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[12] R.C. 1753.28(L)(1) and (A)(2) and 3923.65(L)(1) and (A).

[13] R.C. 1753.28(L)(2), (3), and (M) and 3923.65(L)(2), (3), and (M).

[14] R.C. 1753.28(M) and 3923.65(M).

[15] R.C. 1753.28(N) and 3923.65(N) and R.C. 3901.21 and 3901.22, not in the bill.

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

Definitions

Emergency medical condition

The bill amends the definition of "emergency medical condition" to specify that it applies to both physical and mental health conditions, that the final presumptive diagnosis does not matter for the definition, and that it encompasses a pregnant woman having contractions if certain conditions are met. The below table compares the current definition of the bills:

Current law	H.B. 270
Definition of "emergency medical condition"	
A *medical condition* that manifests itself by such acute symptoms of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention *to* result in any of the following: ▪ Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; ▪ Serious impairment to bodily functions; ▪ Serious dysfunction of any bodily organ or part *(R.C. 1753.28(A) and 3923.65(A)).*	A *physical or mental health condition* that manifests itself by such acute symptoms of sufficient severity that, *regardless of final or presumptive diagnosis,* a prudent layperson with an average knowledge of health and medicine could reasonably expect either of the following: ▪ That the absence of immediate medical attention *could* result in any of the following: ▫ Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; ▫ Serious impairment to bodily functions; ▫ Serious dysfunction of any bodily organ or part. ▪ With respect to a pregnant woman who is having or is believed to be having contractions, that there is: ▫ Inadequate time to effect a safe transport of the woman to another hospital before delivery; ▫ A threat to the health or safety of the woman or unborn child if the woman does not have access to immediate medical attention. *(R.C. 1753.28(A) and 3923.65(A).)*

Emergency services

The bill amends the definition of "emergency services," defining it as any health care service furnished or required in order to determine whether an emergency medical condition exists and the appropriate care to treat, stabilize, or treat and stabilize the emergency condition

in an emergency facility (a hospital emergency department or any other facility that provides emergency medical services) or emergency setting.

Current law defines "emergency services" to mean the following:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to *stabilize* an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital.

"Stabilize," in the context of a health insuring corporation, means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta. The bill removes this definition; note, in current law, there is no definition of "stabilize" in the corresponding provision for sickness and accident insurers.[17]

HISTORY

Action	Date
Introduced	04-22-21

H0270-I-134/ts

[17] R.C. 1753.28(A)(1) and (3) and 3923.65(A), with conforming changes in R.C. 3727.09 and 4765.01.