3901-8-17 **Reimbursement for unanticipated out-of-network care.**

(A) Purpose

The purpose of this rule is to implement sections 3902.50 to 3902.54 of the Revised Code.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3902.50 to 3902.54 of the Revised Code.

(C) Scope

This rule applies to all unanticipated out-of-network care as defined in section 3902.50 of the Revised Code.

(D) No private cause of action

Nothing herein shall be construed to create or imply a private cause of action for a violation of this rule.

(E) Definitions

As used in this rule:

(1) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(2) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

(3) "Cost sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(4) "Covered person," "health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(5) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(6) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(a) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(b) Treatment necessary to stabilize an emergency medical condition; and

(c) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(7) "Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of- network provider when either of the following conditions applies:

(a) The covered person did not have the ability to request such services from an in-network provider.

Clinical laboratory services provided by an out-of-network provider, but that are ordered by an in-network provider, shall be considered to have met the condition prescribed in paragraph (E)(7)(a) of this rule unless the provider rendering the laboratory services discloses its network status in writing to the covered person before the services are provided.

(b) The services provided were emergency services.

(F) Health plan issuer reimbursement for unanticipated out of network care

(1) Use of geographic region in calculation of health plan issuer reimbursement amount. For purposes of determining the amount negotiated with in-network providers, facilities, emergency facilities, or ambulances for the service in question in a geographic region under a health benefit plan, a health plan issuer shall use the geographic region in which the service was performed. The geographic regions in this state shall consist of one region for each metropolitan statistical area, as described by the U.S. office of management and budget and published by the U.S. census bureau, and one region consisting of all other portions of the state.

(2) Application of prompt pay requirements to health plan issuer reimbursement. A health plan issuer shall send an initial claim payment as its intended reimbursement required by division (B)(1) of section 3902.51 of the Revised Code to the provider, facility, emergency facility, or ambulance in compliance with sections 3901.38 to 3901.3814 of the Revised Code.

(3) A health plan issuer shall pay all reimbursement amounts for unanticipated out-of-network care directly to the provider, facility, emergency facility, or ambulance in accordance with division (B)(1) of section 3902.51 of the Revised Code.

Any amounts paid by a health plan issuer for unanticipated out-of-network care shall include remittance advice remark codes to identify that the payment is made pursuant to division (B)(1) of section 3902.51 of the Revised Code.

(4) In a request for reimbursement of a health care service subject to this rule, the provider, facility, emergency facility, or ambulance shall include the proper billing code for the service for which reimbursement is requested.

Such request for reimbursement shall also include:

(a) Sufficient information for the health plan issuer to identify the facility where a health care service was provided;

(b) Sufficient information for the health plan issuer to identify a request for reimbursement where the provider, facility, emergency facility, or ambulance, has met the good faith estimate and affirmative consent conditions contained in division (E)(1) of section 3902.51 of the Revised Code; and

(G) Health plan issuer identification cards

Identification cards provided to a covered person, if any, must clearly and conspicuously denote the letters "ODI" prominently displayed on the front of the card or document.

If a health plan issuer permits providers to access a covered person's eligibility or coverage information through an electronic system, the system must prominently display a statement that the covered person's health benefit plan is subject to sections 3902.50 through 3902.54 of the Revised Code.

(H) Covered person cost sharing amount

(1) A health plan issuer shall not require cost sharing for any service described in division (A) of section 3902.51 of the Revised Code from the covered person at a rate higher than if the services were provided in-network.

(2) For purposes of this rule, the in-network rate for cost sharing shall be a dollar amount calculated at the time the health plan issuer calculates the initial reimbursement amount required in division (B)(1) of section 3902.51 of the Revised Code.

(3) The covered person's cost sharing amount shall not be adjusted due to the outcome of any subsequent negotiation or arbitration between the health plan issuer and provider, facility, emergency facility, or ambulance.

(I) Negotiation in lieu of accepting issuer reimbursement

(1) The provider, facility, emergency facility, or ambulance shall, within thirty business days of receiving reimbursement for unanticipated out of network care, notify the health plan issuer that the provider, facility, emergency facility or ambulance chooses to negotiate reimbursement.

(2) Failure to notify the health plan issuer of an intent to negotiate within the timeframe set forth in paragraph (I)(1) of this rule shall be considered acceptance of the health plan issuer's reimbursement.

(3) If the provider, facility, emergency facility, or ambulance timely notifies the health plan issuer of its intent to negotiate in accordance with the requirements of this rule, the health plan issuer shall, upon request, disclose to the provider, facility, emergency facility, or ambulance each reimbursement amount the health plan issuer calculated for the claim pursuant to division (B)(1) of section 3902.51 of the Revised Code.

(4) If, during a period of negotiation, the health plan issuer and the provider, facility, emergency facility or ambulance agree on a new reimbursement rate for a claim, then the health plan issuer shall send payment directly to the provider, facility, emergency facility or ambulance within thirty calendar days.

(5) If, during a period of negotiation, the health plan issuer and the provider, facility, emergency facility or ambulance agree on a reimbursement rate for a claim, then that claim is not eligible for arbitration.

(6) If negotiation pursuant to paragraph (I) of this rule has not successfully concluded within thirty business days, or if both parties agree that they are at an impasse, a provider, facility, emergency facility, or ambulance may choose to arbitrate that claim so long as the claim meets the eligibility requirements of division (A)(1) of section 3902.52 of the Revised Code.

(J) Arbitration

(1) Requests for arbitration:

(a) A provider, facility, emergency facility, or ambulance may request arbitration to determine the reimbursement for a claim or claims that are eligible for arbitration pursuant to section 3902.52 of the Revised Code.

(b) Requests for arbitration shall be submitted to the superintendent electronically on a form or through a system prescribed by the superintendent.

(c) Upon receipt of a complete request for arbitration, the superintendent shall notify the contracted arbitration entity of the request for arbitration within four business days.

(d) The contracted arbitration entity shall assign an arbitrator within ten business days and shall provide notice to the health plan issuer and provider, facility, emergency facility, or ambulance.

(e) Each party shall submit its final offer and supporting evidence, if any, to the arbitrator within ten business days after an arbitrator is assigned.

The final offer submitted to the arbitrator by either party shall be an amount the submitting party considers a fair reimbursement rate.

(f) The arbitrator shall consider the evidence submitted by the parties and render a decision within thirty business days.

(g) If the arbitrator determines that the final offer submitted by the provider, facility, emergency facility, or ambulance best reflects a fair reimbursement rate, the health plan issuer shall pay the difference, if any, between the reimbursement rate selected by the arbitrator and the initial payment made by the health plan issuer pursuant to division (B)(1) of section 3902.51 of the Revised Code.

The health plan issuer shall pay the reimbursement directly to the provider, facility, emergency facility, or ambulance within thirty calendar days of the arbitrator's decision.

(h) If the arbitrator determines that the final offer submitted by the health plan issuer best reflects a fair reimbursement rate, the provider, facility, emergency facility, or ambulance shall pay the health plan issuer the difference, if any, between the health plan issuer's reimbursement rate selected by the arbitrator and the initial payment made by the health plan issuer pursuant to division (B)(1) of section 3902.51 of the Revised Code.

The provider, facility, emergency facility, or ambulance, shall pay the reimbursement directly to the health plan issuer within thirty calendar days of the arbitrator's decision.

(2) Claims bundling.

(a) For purposes of bundling claims for arbitration, provider includes a practice of providers to the extent such providers contract with health plan issuers as a single practice.

(b) If negotiation pursuant to division (B)(2) of section 3902.51 of the Revised Code is unsuccessful, a provider, facility, emergency facility, or ambulance may choose to arbitrate that claim as a bundle of up to fifteen claims at a later date, so long as all of the claims meet the requirements of division (A)(1) of section 3902.52 of the Revised Code.

(3) Costs.

(a) The arbitration entity shall perform each arbitration on a flat fee basis.

(b) There shall be no additional costs for a single arbitration of up to fifteen bundled claims.

(c) The non-prevailing party shall pay seventy per cent of the arbitrator's fees, and the prevailing party shall pay thirty per cent.

(i) For purposes of this rule, the non-prevailing party shall be the party whose final offer was not selected by the arbitrator. If multiple claims are bundled for a single arbitration, the non-prevailing party shall be the party whose final offer for each claim was selected fewer times by the arbitrator.

(ii) For purposes of this rule, the prevailing party shall be the party whose final offer was selected by the arbitrator. If multiple claims are bundled for a single arbitration, the prevailing party shall be the party whose final offer for each claim was selected more times by the arbitrator.

(d) In the event that multiple claims are bundled in a single arbitration and the arbitrator selects a final offer from each party the same number of times, then there is no prevailing party and each party shall pay fifty per cent of the arbitrator's fees.

(e) Each party shall bear their own costs for all other expenses related to arbitration.

(4) Submission of evidence for purposes of arbitration.

(a) Each party may submit evidence relating to the factors contained in division (C) of section 3902.52 of the Revised Code except:

(i) No party may submit billed charges as evidence.

(ii) No party may submit public payer rates such as medicare or medicaid reimbursement amounts as evidence.

(b) Evidence must be in a form that can be verified and authenticated.

(c) Evidence must be in a format compatible with the secure portal utilized by the arbitration entity.

(K) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.

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CERTIFIED ELECTRONICALLY

Certification

12/20/2021

Date

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