# 4123-6-51 Employer participation in the QHP system - bureau certification of QHPs. (No Change)

(A) A health plan that satisfies the QHP certification requirements of this chapter shall be certified by the bureau as a QHP to manage medical treatment, direct care or provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under Chapter 4121., 4123., or 4131. of the Revised Code.

(B) An employer may establish a bureau certified QHP, that shall comply with the thirteen standards set forth in divisions (A)(1) to (A)(13) of section 4121.442 of the Revised Code, division (P) of section 4121.44 of the Revised Code, and rules 4123-6-53 and 4123-6-54 of the Administrative Code.

(C) The bureau is authorized to recertify QHPs at least every three years.

(D) The bureau, at least annually, shall develop and make available information that describes employer and employee rights under the QHP.

(E) The bureau shall continue to certify health plans and shall periodically, at least annually, update its list of certified QHPs.

# 4123-6-52 Employer participation in the QHP system - bureau recertification of QHPs. (No Change)

(A) The bureau shall initiate the recertification process by sending certified QHPs a recertification application, which must be completed, signed and submitted to the bureau if the QHP wishes to be considered for recertification.

(B) Except as otherwise provided in paragraph (E) of this rule, if the bureau receives a completed and signed recertification application from a QHP, the QHP's certification shall remain in effect until the bureau issues a final order approving or denying the QHP's application for recertification.

(C) If the bureau does not receive a completed and signed recertification application from the QHP within sixty days from the date of the notice sent in accordance with paragraph (A) of this rule, the bureau shall send a second notice to the QHP stating that the QHP has thirty days from the date of the second notice to complete, sign and submit the recertification application to the bureau if the QHP wishes to be considered for recertification.

(D) If the bureau does not receive a completed and signed recertification application from the QHP within thirty days from the date of the notice sent in accordance with paragraph (C) of this rule, the QHP's certification shall lapse. Such lapse of certification is not an adjudication order and is not subject to appeal pursuant to rule 4123-6-17 of the Administrative Code.

(E) If the bureau receives a completed and signed recertification application from a QHP after the QHP's certification has lapsed pursuant to paragraph (D) of this rule, the QHP's certification shall remain lapsed until the bureau issues a final order approving or denying the QHP's application for recertification.

# 4123-6-53 Employer participation in the QHP system - QHP quality assurance program required. (No Change)

(A) Each QHP shall have a quality assurance program that monitors the operation and measures the effectiveness of peer review, utilization review, and dispute resolution within the QHP. Data collected from the quality assurance program shall be used to assist an employer in determining the quality, efficiency and effectiveness of the employer's QHP and the QHP system in accordance with division (A) of section 4121.442 of the Revised Code.

(B) Each quality assurance program shall include a mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with each of the following eleven elements:

(1) Peer review and evaluation of clinical performance;

(2) Credentialing and recredentialing and use of provider profiling;

(3) Utilization management to determine the appropriateness of care;

(4) Evaluation of employee and provider dispute resolution procedures and outcomes;

(5) Evaluation of outcomes of care based on clinical data;

(6) Procedures for remedial action for inappropriate or substandard services;

(7) Evaluation of employee satisfaction with the plan;

(8) Evaluation of provider satisfaction with the plan;

(9) Evaluation of employer satisfaction with the plan;

(10) Periodic evaluation of medical records and office procedures; and

(11) Practice patterns compared to accepted medical criteria.

(C) The quality assurance program shall include a quality assurance committee or other mechanism adequate to evaluate the outcomes of each of the eleven elements listed in paragraph (B) of this rule.

# 4123-6-55 Employer participation in the QHP system - bureau's authority to decertify, to refuse to certify or recertify a QHP. (No Change)

(A) The bureau is authorized to decertify, to refuse to certify or recertify a QHP from participation in the QHP system.

(B) Should the bureau determine that sufficient evidence exists that an employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs, the bureau, shall take one of two courses of action:

(1) The bureau shall notify the employer, employee representative and QHP in writing by certified mail of the facts and issues relating to the bureau's determination that the employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs. Such notice shall set forth a period of time for the employer or QHP to resolve or correct the problem. Failure of the employer or QHP to resolve or correct the problem within the time period shall result in notification from the bureau to the employer and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

(2) Notify the employer, employee representative and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

(3) For the purpose of this rule, "employee representative" does not include the employee's attorney.

(C) Upon a final order of the administrator to decertify, refuse to recertify, or revoke or suspend the certification of a QHP, employees and employers shall not receive services from such QHP pursuant to the QHP system.

# 4123-6-58 Provider access to the QHP system - provider participation in QHP system and other related health care program not linked. (No Change)

A QHP or vendor that provides medical management and cost containment services shall not require a provider to participate in a workers' compensation network of providers in order to maintain membership in a related health care program. If the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed, written consent of the provider has been obtained.

# 4123-6-65 Payment in the QHP system - employer payment to vendor that provides medical management and cost containment services and/or QHPs. (No Change)

The bureau shall not interfere with nor impose restrictions upon an arrangement for payment negotiated between an employer and a vendor that provides medical management and cost containment services and/or a QHP under the QHP system, except that no financial arrangement between an employer and a vendor that provides medical management and cost containment services and/or a QHP shall incentivize a reduction in the quality of medical care received by an injured worker.

**4123-6-54 Employer participation in the QHP system - QHP certification application. (Amend)**

(A) Upon request by an employer or health plan seeking certification, the bureau shall mail the employer or health plan seeking certification a QHP application for certification.

(B) The QHP application for certification shall include a list of bureau certified providers in the QHP's provider network.

(C) The QHP application for certification shall include, at a minimum, the following provisions, as more fully detailed within the QHP certification application itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit;

(2) Proof that a self-insured employer has been granted status as a self-insured employer in accordance with section 4123.35 of the Revised Code;

(3) A description of the geographic or regional area of the state of Ohio to be serviced by the QHP, taking into account the unique circumstances of the individual employer, such as multiple locations, and/or the need for a statewide network;

(4) A description of the role of each vendor that will be a component of the QHP including, but not limited to, the following: if an employer uses or anticipates using company-based providers, a description of the role of company-based providers as distinguished from QHP network providers; if an employer uses or anticipates using a third party administrator, a description of the role of the third party administrator;

(5) If an employer contemplates contracting with a vendor that has been certified by the bureau under Chapter 4123-6 of the Administrative Code to provide services under the employer's QHP, proof that certification has been granted by the bureau and that such certification is current;

(6) A description of the structure of the medical management component and the health care provider network to be offered by the QHP;

(7) A description of the QHP's plan and methodology for providing, at least annually, QHP network provider information, by provider type, and updated QHP network provider directories to employees;

(8) A description of the QHP's quality assurance program, including but not limited to, the proposed structure and operation and a description of the mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with the elements listed in paragraph (B) of rule 4123-6-53 of the Administrative Code;

(9) A description of the QHP's employee education program. The description shall include but shall not be limited to: a description of the process to be used to educate employees regarding their rights and responsibilities in the QHP system; a description of the process to be used to explain the time, place and manner of services to be delivered under the QHP; and a description of the process to be used to explain options available to injured workers, including the process for changing providers within the QHP and referral and transfer to the HPP; and

(10) A description of the plan satisfactory to the bureau to be implemented by the QHP in the event a final order to revoke certification, or to refuse to recertify a QHP is issued by the administrator, pursuant to rule 4123-6-55 of the Administrative Code, that includes, but is not limited to, a plan that describes continuation and continuity of care of injured workers~~;~~ and a plan that describes payment of providers for medical services rendered prior to revocation of certification or refusal to certify. The injured worker may continue receiving medical services from the same provider or may choose a provider in a new approved plan for delivery of medical services, both of whom shall accept medical management of the medical services through the employer's new approved plan.

(D) The bureau shall review the application for certification submitted by the health plan seeking certification. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(E) The bureau shall hold as confidential and proprietary the vendor's descriptions of process, methodology, policies, procedures and systems as required for the application for certification, to the extent such qualify as a "trade secret" under division (D) of section 1333.61 of the Revised Code.

**4123-6-59 Provider access to the QHP system - QHP provider selection. (Amend)**

(A) An employer that develops a QHP, a vendor within the QHP system, or a QHP shall develop and implement standards of credentialing of providers in the QHP network that meet but may exceed the bureau credentialing requirements in the HPP.

(B) An employer that develops a QHP may selectively contract with providers or contract with a vendor that selectively contracts with providers.

(C) Only a bureau certified provider is eligible for selection by an employer that develops a QHP, by a QHP as a QHP panel provider or by a vendor as a panel provider to participate in the QHP system. A provider identified by a QHP for inclusion in its panel of providers that is not a bureau certified provider may be assisted by the QHP in applying for bureau provider credentialing and certification.

(D) The bureau, an employer, a QHP or a vendor shall not discriminate against any category of health care provider when establishing categories of providers for participation in the QHP system. However, an employer, a QHP or a vendor is not required to accept or retain any individual provider in the QHP system.

(E) The bureau, an employer, a QHP and a vendor shall comply with state and federal laws prohibiting discrimination based on~~, but not limited to,~~ race, color, religion, sex, age, disability, military status as defined in section 4112.01 of the Revised Code, national origin, ancestry, or ~~color, and shall not discriminate against any health care provider when establishing categories of providers for participation in the QHP system on the basis of race, religion, national origin, color, gender,~~ sexual orientation. ~~or age.~~

(F) A QHP shall include in its panel a substantial number of the medical, professional, and pharmacy providers currently being utilized by employees. A QHP may limit the number of providers on its provider panel, but shall do so based upon objective data that demonstrates that the fundamental needs of the employer and employees are met based on reasonable standards such as historical claims data or other geographic information approved by the bureau. In addition, a QHP shall include in its application for QHP certification information including reasonable patient access, the potential number of employees the QHP is applying to service, and other performance criteria, without discrimination by provider type. A QHP seeking QHP certification may select out-of-state providers as members of the QHP panel.

**4123-6-69 QHP dispute resolution process. (Amend)**

(A) This rule shall provide time frames and procedures for review of requests for the delivery of medical services and for the resolution of disputes that may arise between an employee and an employer, an employee and a provider, or an employer and a provider. This rule applies to, but is not limited to, reviews of records, medical disputes arising over issues such as, but not limited to, quality assurance, utilization review, a determination that a service provided to an employee is not covered, is covered or is medically unnecessary; or disputes involving individual health care providers.

(B) Initial review and decision upon requests for the delivery of medical services that include, but are not limited to, medical treatment, major diagnostic testing, hospitalization, surgery and physical therapy, shall be completed by the QHP. The employee, employer and provider shall be notified verbally of the outcome of the initial review within forty-eight hours of the request. Within seven working days of the verbal notification, the verbal notification shall be committed to writing and mailed to the employee, employer and provider.

(C) A QHP shall have a dispute resolution process beyond initial review that includes ~~a minimum of two levels of peer review of a medical diagnosis or treatment issue if an individual health care provider is involved in the dispute, or a minimum of two levels of dispute resolution if an individual health care provider is not involved in the dispute~~ one independent level of professional review.

(D) A QHP dispute resolution process shall be completed and the QHP shall notify the parties to the dispute and their representatives in writing within twenty-one days of the initial written notice of a dispute, unless an extension of time is otherwise agreed to by the parties. ~~Any party appealing a decision to a higher level within a QHP's dispute resolution process shall provide notice of such appeal to all the parties to the dispute within seven working days of notice of decision.~~ If the QHP schedules the injured worker for an independent medical examination for the independent level of professional review, the twenty-one day time frame shall be tolled, and in such cases the QHP shall complete the dispute resolution process within seven days after receipt of the independent medical examination report.

(E) The dispute resolution process shall begin upon written notice of the dispute by the party maintaining the dispute to the parties of the dispute. ~~If~~

(1) If an individual health care provider ~~is involved in the dispute, there shall be available at least two levels of peer review if appealed, with at least one level conducted by an individual or individuals licensed pursuant to the same section of the revised code as the health care provider who is a party to the dispute. The other level of peer review shall include, at the discretion of the QHP medical director, one or more of the following: a review conducted by a~~

~~multi-disciplinary medical panel or board; an independent or agreed upon medical examination; or the use of other resources beneficial to the resolution of the dispute~~ eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a peer review conducted by an individual or individuals licensed pursuant to the same section of the Ohio Revised Code as the health care provider who would be providing the services requested.

(2) Notwithstanding paragraph (E)(1) of this rule, if the QHP has already obtained one or more peer reviews during previous disputes involving the same or similar treatment, the QHP may obtain a different perspective review from a licensed physician who falls outside the peer review criteria set forth above.

(3) ) If an individual health care provider not eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a provider review conducted by an individual or individuals eligible to be physician of record whose scope of practice includes the services requested.

(4) If the QHP receives a dispute where the requested treatment appears to be the same as or similar to a previous treatment request for which the QHP conducted a professional review, and the previous treatment request was ultimately denied based on the professional review, the QHP may use the previous professional review to satisfy the independent level of professional review requirement of this paragraph.

(F) A dispute unresolved by a QHP dispute resolution process may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

(G) Notwithstanding the requirements set forth in paragraph (F) of this rule, a dispute unresolved by a QHP providing medical management and cost containment services for a state fund employer shall be referred by the QHP to the bureau within seven working days of the final decision rendered within the QHP dispute resolution process. Within fourteen days of receipt of an unresolved medical dispute, the bureau shall conduct an independent review of the unresolved medical dispute received from the QHP and enter a final bureau order pursuant to section 4123.511 of the Revised Code. This order shall be mailed to all parties and may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

# 4123-6-70 Evaluation of the QHP system by the bureau; reporting requirements by employers and QHPs. (No Change)

(A) To enhance the quality of the QHP system, and pursuant to division (A)(9) of section 4121.442 of the Revised Code , the administrator shall require employers and QHPs that participate in the workers' compensation QHP system to report data to be used by the administrator to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers compensation system.

(B) The bureau shall evaluate the effectiveness of the QHP system based on standardized data and reporting requirements developed by the bureau.

(C) The bureau shall receive, define and publish data elements and data collection techniques that meet the thirteen standards set forth in divisions (A)(1) to (A)(13) of section 4121.442 of the Revised Code and are necessary to evaluate the effectiveness of the QHP system. Performance indicators used by the bureau to evaluate the effectiveness of the QHP system may include, but shall not be limited to, the following: customer satisfaction; system cost drivers; improvements in quality, and cost reductions.

## 4123-6-72 Confidentiality. (No Change)

Subject to the requirements and protections contained in Ohio law pertaining to release of confidential and/or privileged information, in the course of medical management in the QHP system, confidential information may be exchanged among the bureau, the QHPs, an employer and its representative, an employee and their representative, and the provider. All parties providing or requiring such confidential information for use in the QHP system shall not provide or use such confidential information for any purpose other than to perform duties required under the QHP system, and shall prevent such information from further disclosure or use by unauthorized persons.