OPINION NO. 99-044

Syllabus:

1. Pursuant to R.C. 1751.08(D), the rendering of an opinion as to the medical necessity of physician medical services for purposes of utilization review as defined in R.C. 1751.77(N) and governed by R.C. 1751.77-.86 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731.

2. Pursuant to R.C. 1751.08(D), the rendering of an opinion by a physician as to the medical necessity of physician medical services during an appeal of an adverse determination conducted under R.C. Chapter 1751 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731.

3. Pursuant to R.C. 1751.08(D), a physician's rendering of a medical necessity opinion during the course of utilization review conducted under R.C. Chapter 1751 is not considered to be the practice of medicine and is not subject to review by the State Medical Board as an act of medical practice; however, the physician remains subject to the jurisdiction of the State Medical Board under R.C. 4731.22 in other respects.

To: Anita M. Steinbergh, State Medical Board of Ohio, Columbus, Ohio
By: Betty D. Montgomery, Attorney General, August 31, 1999

You have requested an opinion concerning the circumstances in which "decisions made by Ohio licensed physicians and others on behalf of health insuring corporations fall within the purview of the State Medical Board." You have asked three specific questions:

1. Does the rendering of an opinion as to the medical necessity of physician medical services proposed or provided constitute the practice of medicine when the opinion is offered for purposes of utilization review, as that term is defined in Section 1751.77(N), Ohio Revised Code?

2. Does the rendering of an opinion as to the medical necessity of physician medical services proposed or provided constitute the practice of medicine when the opinion is offered by an Ohio licensed physician during an appeal of an adverse determination conducted under Chapter 1751., Ohio Revised Code?

3. Whether or not an Ohio licensed physician's rendering of a medical necessity opinion during the course of utilization review conducted under Chapter 1751., Ohio Revised Code, including during an adverse determination appeal, constitutes the practice of medicine, are the physician's actions subject to review by the State Medical Board when the Board has received a complaint alleging that the physician violated Section 4731.22, Ohio Revised Code in formulating or offering that opinion?

Your specific questions relate to activities involved in utilization review procedures, including adverse determination appeals, and this opinion is confined to those activities.

You have not asked that we consider specific facts but have stated generally that the State Medical Board has received a number of complaints regarding instances in which health insuring corporations have denied coverage for health care services based on the lack of medical necessity. Complainants have alleged that these adverse determinations involve violations of the statutes governing the practice of medicine in Ohio. Your request letter states:

> Complainants have alleged that health insuring corporations, or their predecessor organizations such as health maintenance organizations, practiced medicine without a license by making clinical decisions that impacted on a [patient's] health, that individual company employees or agents who actually performed utilization reviews practiced medicine without a license, and that licensed physicians

> employed by the companies violated one or more provisions of Section 4731.22, Ohio Revised Code, the disciplinary statute enforced by the State Medical Board.

In order to answer your questions, let us begin with an examination of the powers of the State Medical Board. The State Medical Board is authorized to issue certificates for the practice of medicine. R.C. 4731.14. The practice of medicine without such a certificate is prohibited, and criminal penalties are provided. R.C. 4731.41; R.C. 4731.99. The State Medical Board is authorized to limit, revoke, or suspend a certificate or otherwise discipline the holder of a certificate who commits any of a number of violations. R.C. 4731.22(A); R.C. 4731.22(B)(1)-(35). The Board also has authority to investigate possible violations of the statutes and rules governing the practice of medicine, to hold hearings, and to share its information with other licensing boards and with law enforcement agencies. R.C. 4731.22(F). The Board may seek injunctions against the unauthorized practice of medicine or bring criminal charges. R.C. 4731.341; R.C. 4731.39; R.C. 4731.99; *see State ex rel. Lakeland Anesthesia Group, Inc. v. Ohio State Med. Bd.*, 74 Ohio App. 3d 643, 600 N.E.2d 270 (Cuyahoga County 1991). Thus, the State Medical Board has authority to regulate the practice of medicine, to investigate allegations of violations of provisions governing the practice of medicine, and to enforce those provisions.

For purposes of regulation by the State Medical Board, a person is regarded as practicing medicine if the person uses words, letters, or a title "in connection with the person's name that in any way represents the person as engaged in the practice of medicine," or if the person:

> *examines or diagnoses for compensation* of any kind, or *prescribes, advises, recommends, administers, or dispenses for compensation* of any kind, direct or indirect, *a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature*, for the cure or relief of a wound, fracture or bodily injury, infirmity, or disease ...; ... provided ... that ... no person shall be denied the benefits of accepted medical and surgical practices.

R.C. 4731.34 (emphasis added). Hence, the State Medical Board has regulatory, investigatory, and enforcement authority over persons who engage in such activity.

To address your concerns, we must also consider the statutory provisions that govern health insuring corporations and the procedures under which they operate. Those provisions appear in R.C. Chapters 1751 and 1753.

A health insuring corporation is a corporation that "pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or other-

wise makes available," basic health care services,[1] supplemental health care services,[2] or specialty health care services,[3] or a combination of services, through either an open panel plan or a closed panel plan. R.C. 1751.01(N). A health insuring corporation is subject to

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[1] As defined for purposes of R.C. Chapter 1751:

> (A) *"Basic health care services" means the following services when medically necessary*:
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> (1) Physician's services, except when such services are supplemental under division (B) of this section;
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> (2) Inpatient hospital services;
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> (3) Outpatient medical services;
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> (4) Emergency health services;
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> (5) Urgent care services;
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> (6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;
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> (7) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.
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> "Basic health care services" does not include experimental procedures.
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> A health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in Title XVII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

R.C. 1751.01(A) (emphasis added).

[2] As defined for purposes of R.C. Chapter 1751, supplemental health care services include such services as dental or vision care, home health services, prescription drug services, nursing services, and other services approved by the Superintendent of Insurance. R.C. 1751.01(B).

[3] As defined for purposes of R.C. Chapter 1751, specialty health care services are supplemental health care services when provided on an outpatient-only basis and not in combination with other supplemental health care services. R.C. 1751.01(C).

regulation by the Superintendent of Insurance and the Director of Health and is required to obtain a certificate of authority pursuant to R.C. Chapter 1751. *See* R.C. 1751.02-.05; R.C. 1751.12; R.C. 1751.32-.321; R.C. 1751.34-.35; *see also* R.C. 1753.09(G). A health insuring corporation is required to establish and maintain a complaint system that has been approved by the Superintendent of Insurance. R.C. 1751.19. A health insuring corporation that provides basic health care services must implement a quality assurance program that is certified by the Superintendent of Insurance. R.C. 1751.73-.75.

Utilization review programs are governed by R.C. 1751.77-.86.[4] Utilization review provisions are mandatory, *see* R.C. 1751.86, but no utilization review is required for supplemental health care services or specialty health care services, *see* R.C. 1751.78(A)(2). Utilization review may be conducted either by the health insuring corporation itself or by delegation of that task to another entity, such as a utilization review organization. R.C. 1751.78.[5] A health insuring corporation that contracts to have another entity perform utilization review functions must monitor that entity and ensure that applicable requirements are met. R.C. 1751.78(B)(2); R.C. 1751.80(D). The review activities must include procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services. R.C. 1751.79(A).

In general, the determination by a health insuring corporation as to whether to pay for, reimburse, or provide particular services is made in accordance with R.C. 1751.81 and is referred to as a "utilization review determination." R.C. 1751.80; R.C. 1751.81. After obtaining all necessary information, the health insuring corporation must decide whether to certify[6] an admission, procedure, or health care service. R.C. 1751.81. A determination not to certify the admission, procedure, or health care service is known as an adverse determina-

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[4] "Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

R.C. 1751.77(N).

[5] "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans.

R.C. 1751.77(O).

[6] *"Certification"* means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, *the health care service satisfies the health insuring corporation's requirements for benefit payment.*

R.C. 1751.77(D) (emphasis added). As effective May 1, 2000, the definition will read as follows:

> "Certification" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, the health care service satisfies

tion[7] and is subject to a request for reconsideration or an appeal. R.C. 1751.81; R.C. 1751.82.

The utilization review program of a health insuring corporation must "use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy." R.C. 1751.80(A). The program must be administered by "[q]ualified providers," who also must oversee review determinations. R.C. 1751.80(B).[8] In the event of an appeal, "[a] clinical peer in the same, or in a similar, specialty as typically manages the medical condition, procedure, or treatment under review shall evaluate the clinical appropriateness of adverse determinations that are the subject of [the] appeal." *Id.*[9]

> the requirements for benefit payment under the health insuring corporation's policy, contract, or agreement.

R.C. 1751.77(E), as amended and relettered by Am. Sub. H.B. 4, 123rd Gen. A. (1999) (eff. Oct. 14, 1999, with amendments to R.C. 1751.77 eff. May 1, 2000).

[7] *"Adverse determination"* means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, *the health care service does not meet the health insuring corporation's requirements for benefit payment*, and is therefore denied, reduced, or terminated.

R.C. 1751.77(A) (emphasis added). As effective May 1, 2000, the definition will read as follows:

> "Adverse determination" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, the health care service does not meet the requirements for benefit payment under the health insuring corporation's policy, contract, or agreement, and coverage is therefore denied, reduced, or terminated.

R.C. 1751.77(A), as amended by Am. Sub. H.B. 4, 123rd Gen. A. (1999) (eff. Oct. 14, 1999, with amendments to R.C. 1751.77 eff. May 1, 2000).

[8] "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under [R.C. Chapter 1785], provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physicians' assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

R.C. 1751.01(W).

[9] "Clinical peer" means a physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a provider who is

A health insuring corporation must certify to the Superintendent of Insurance that all provider contracts and contracts with health care facilities through which health care services are provided include a provision specifying that a provider or health care facility is not permitted to seek remuneration from a subscriber or enrollee for heath care services provided pursuant to the agreement, but may collect authorized copayments or fees for uncovered health services delivered on a fee-for-service basis. R.C. 1751.13(C)(2). The provider or health care facility is prohibited by statute from seeking "compensation for covered services" from the enrollees or subscribers, except for approved copayments. R.C. 1751.60(A). The provider or health care facility is permitted, however, to bill the enrollee or subscriber for "noncovered services." R.C. 1751.60(D).

It is sometimes stated that, if a health insuring corporation refuses to certify a health care service, the patient will be unable to obtain the service in question, even though his personal physician recommends it. It should be noted, however, that an adverse determination by a health insuring corporation means that the health insuring corporation will not pay for, reimburse, provide, deliver, arrange for, or otherwise make available the service in question. *See* R.C. 1751.01(N); *see also* R.C. 1751.77(A). It does not mean that the physician is precluded from providing the service or that the patient is precluded from obtaining the service from another source or through other means.

As a matter of law, a health insuring corporation must certify to the Superintendent of Insurance that all provider contracts and contracts with health care facilities through which health care services are provided include a provision requiring the provider or health care facility "to provide health care services without discrimination on the basis of a patient's participation in the health care plan ... and without regard to the source of payments made for health care services rendered to a patient." R.C. 1751.13(C)(9).[10] Accordingly, a health insuring corporation's adverse determination does not prevent the provider from providing services that are not certified. A physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation.[11]

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not a physician, "clinical peer" means either a physician or a provider holding the same license as the provider who provided the health care services.

R.C. 1751.77(E). "'Physician' means a provider authorized under [R.C. Chapter 4731] to practice medicine and surgery or osteopathic medicine and surgery." R.C. 1751.77(J).

[10] An exception applies to circumstances in which the provider or health care facility does not render services due to lack of training, experience, or skill or due to licensing restrictions. R.C. 1751.13(C)(9).

[11] A physician also has a legal and ethical obligation regarding the provision of appropriate health care for a patient. *See* R.C. 4731.34 (including as part of the practice of medicine that "no person shall be denied the benefits of accepted medical and surgical practices"); American Med. Ass'n, Council on Ethics and Judicial Affairs, *Code of Medical Ethics*, Op. 8.03 ("[i]f a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit"), Op. 8.11 ("[o]nce having undertaken a case, the physician should not neglect the patient"), Op. 8.13(2)(d) ("[p]hysicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests") (1998-1999).

R.C. 1751.08(D) states plainly that a health insuring corporation holding a certificate of authority under R.C. Chapter 1751 "shall not be considered to be practicing medicine." R.C. 1751.08(D). Therefore, the State Medical Board does not have authority to regulate or investigate activities of a health insuring corporation under its authority to regulate and investigate the practice of medicine.

You have raised questions, however, about the authority of the Board to regulate or investigate activities of particular individuals who are involved in the operations of a health insuring corporation. Your letter of request states:

> The State Medical Board must ... consider whether those individuals who actually review the issue and conclude that a service is or is not medically necessary are advising or recommending treatment for purposes of Section 4731.34, Ohio Revised Code, and are [therefore] required to hold a certificate issued by the State Medical Board. Health insuring corporations typically argue that coverage decisions, whether made by licensed physicians or by ancillary health care personnel, are decisions only as to what services the company will pay for, not as to what services providers may render. Thus, the argument goes, reviewers who are not licensed by the State Medical Board, whether or not they are trained as physicians, are not practicing medicine. Complainants respond that adverse determinations do, in fact, quite often limit the care that patients actually receive. They argue that a medical necessity decision is, by its very nature, the practice of medicine.

Let us turn now to your first question, which asks whether the rendering of an opinion as to the medical necessity of physician medical services proposed or provided constitutes the practice of medicine when the opinion is offered for purposes of utilization review. Your question does not specify who is rendering the opinion in question. We understand, however, that your question relates to any individual or entity that might render an opinion for or on behalf of a health insuring corporation for purposes of utilization review.

To determine whether the rendering of an opinion as to medical necessity for purposes of utilization review constitutes the practice of medicine, we look to the statutory language providing that a health insuring corporation holding a certificate of authority under R.C. Chapter 1751 "shall not be considered to be practicing medicine." R.C. 1751.08(D). Pursuant to this provision, if a health insuring corporation holds a certificate of authority under R.C. Chapter 1751, the health insuring corporation is not considered to be practicing medicine in the conduct of its utilization review program under R.C. 1751.77-.86, regardless of whether any part of that program might fall within the practice of medicine, as defined in R.C. 4731.34 for purposes of R.C. Chapter 4731. *See generally Propst v. Health Maintenance Plan, Inc.*, 64 Ohio App. 3d 812, 582 N.E.2d 1142 (Hamilton County 1990) (finding under prior law that health maintenance organizations could not be considered to be practicing medicine for purposes of medical malpractice action).

R.C. 1751.08 does not specify that all persons employed by or acting on behalf of a health insuring corporation to carry out a utilization review program under R.C. 1751.77-.86 must similarly be found not to be practicing medicine, but this conclusion follows from principles governing corporations.[12] A corporation can act only through its officers and

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[12] As noted above, your questions relate to activities involved in utilization review procedures, and this opinion is confined to those activities. In particular, the analysis set forth in this opinion does not extend to any activities that might be performed by a provider

agents. *See Scott-Pontzer v. Liberty Mut. Fire Ins. Co.*, 85 Ohio St. 3d 660, 664, 710 N.E.2d 1116, 1119 (1999) (in an insurance policy, use of the word "you" to refer to a corporation "also includes [the corporation's] employees, since a corporation can act only by and through real live persons'.... [N]aming the corporation as the insured is meaningless unless the coverage extends to some person or persons — including to the corporation's employees"); *Arcanum Nat'l Bank v. Hessler*, 69 Ohio St. 2d 549, 557, 433 N.E.2d 204, 211 (1982); *see also* R.C. 1701.59; R.C. 1701.64. A corporation has only the authority granted to it by the Ohio Revised Code and cannot use agents to perform acts which exceed that authority. *See, e.g., Real Estate Capital Corp. v. Thunder Corp.*, 31 Ohio Misc. 169, 174, 287 N.E.2d 838, 842 (C.P. Montgomery County 1972). Hence, when persons act on behalf of a health insuring corporation to carry out a utilization review program pursuant to statute, decisions made by those persons are the acts of the corporation and are subject to the provisions of R.C. 1751.08(D) excluding them from the practice of medicine. *See, e.g.*, R.C. 1751.78 (a health insuring corporation is responsible for monitoring all utilization review activities carried out by or on behalf of the corporation or by a designee of the corporation and for insuring that all statutory and regulatory requirements are met); *see also* R.C. 1751.80. Opinions provided as part of the process of making such decisions similarly are excluded from the practice of medicine.[13] Therefore, pursuant to R.C. 1751.08(D), the rendering of an opinion as to the medical necessity of physician medical services for purposes of utilization review as defined in R.C. 1751.77(N) and governed by R.C. 1751.77-.86 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731.[14]

Let us turn now to your second question, which asks whether the rendering of an opinion as to the medical necessity of physician medical services proposed or provided constitutes the practice of medicine when the opinion is offered by an Ohio licensed physician during an appeal of an adverse determination conducted under R.C. Chapter 1751. The

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or health care facility pursuant to a contract under R.C. 1751.13. In that regard, we note that providers and health care facilities that enter into contracts pursuant to R.C. 1751.13 are governed by statutory provisions different from the ones governing persons involved in utilization review programs, perform different functions, and have a different relationship with the health insuring corporation than persons participating in utilization review. *See, e.g.*, R.C. 1751.13; R.C. 1751.78; R.C. 1751.80.

[13] This reading of the statute is consistent with the principle that statutes defining criminal offenses should be construed strictly against the state and liberally in favor of the accused. R.C. 2901.04(A). Because a violation of the statute prohibiting the unlicensed practice of medicine carries with it criminal penalties, the definition of the practice of medicine should be narrowly construed and the exclusions provided by R.C. 1751.08 should be given their full effect. *See* R.C. 4731.41; R.C. 4731.99.

[14] This conclusion is consistent with the Patient Protection Act of 1999, recently enacted by the General Assembly. Am. Sub. H.B. 4, 123rd Gen. A. (1999) (eff. Oct. 14, 1999, with most statutory provisions eff. May 1, 2000). R.C. 3901.84, effective May 1, 2000, will provide that an independent review organization, and any medical expert or clinical peer the organization uses in an external review of a denial, reduction, or termination of coverage on the basis that the service is not medically necessary, is not liable in damages in a civil action and "is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review." *Id.* However, R.C. 3901.84 will not grant immunity for an action that is outside the scope of authority granted under the statutory external review provisions. *Id.*

question is whether opinions rendered as part of the appeals process of a health insuring corporation constitute the practice of medicine. The discussion set forth above indicates that they do not.

By statute, the General Assembly has expressly excluded from the practice of medicine actions taken by a health insuring corporation. R.C. 1751.08(D). A corporation is itself a legal entity, but it requires the efforts of others, serving as officers and agents, to accomplish its purposes. *See, e.g., Arcanum Nat'l Bank v. Hessler.* When an individual is engaged in the process of determining, on behalf of the corporation, whether particular physician medical services are medically necessary, that individual, by statutory directive, is not considered to be practicing medicine. This conclusion applies even when the individual engaged in the determination process is a physician who is considering the question of medical necessity as part of the process by which an adverse determination of a health insuring corporation is appealed. *See* note 12, *supra*. Therefore, pursuant to R.C. 1751.08(D), the rendering of an opinion by a physician as to the medical necessity of physician medical services during an appeal of an adverse determination conducted under R.C. Chapter 1751 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731. *See* note 14, *supra*.

It is important to note that the State Medical Board has only the authority that it has been granted by statute, and that it cannot expand that statutory authority. *See Rose v. Baxter*, 7 Ohio N.P. (n.s.) 132, 134 (C.P. Franklin County 1908) (state board of medical examiners "can only carry into effect that which the Legislature itself has seen fit to order and direct"), *aff'd*, 81 Ohio St. 522, 91 N.E. 1138 (1909); *see also* 1991 Op. Att'y Gen. No. 91-038. The General Assembly has made health insuring corporations subject to regulation, in various respects, by the Department of Insurance and the Department of Health. *See* R.C. 1751.02-.05; R.C. 1751.12; R.C. 1751.32-.321; R.C. 1751.34-.35; R.C. 3901.01-.011. However, the General Assembly has not granted the State Medical Board authority to oversee or otherwise regulate health insuring corporations or actions of agents or employees performed on behalf of health insuring corporations. *See* R.C. Chapters 1751 and 1753. Absent legislative authority for the State Medical Board to participate in the regulation of health insuring corporations, we are constrained to conclude that such participation exceeds the Board's power. *See, e.g.*, 1991 Op. Att'y Gen. No. 91-038. Hence, for this reason as well, we conclude that the State Medical Board does not have regulatory, investigatory, or enforcement authority over the utilization review process of a health insuring corporation.

Let us turn now to your final question. You have asked whether the actions of an Ohio licensed physician in rendering a medical necessity opinion during the course of utilization review are subject to review by the State Medical Board when the Board has received a complaint alleging that the physician violated R.C. 4731.22 in formulating or offering that opinion.

R.C. 4731.22 sets forth more than thirty reasons for which a physician may be disciplined. The reasons that appear most likely to be the subject of a complaint in the situation with which you are concerned are these:

> (2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;
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> ...

> (6) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established.

R.C. 4731.22(B). These grounds for complaint relate to minimal medical standards of care or treatment of patients. As discussed above, a physician's rendering of an opinion of medical necessity for purposes of utilization review is not considered to constitute the practice of medicine. Therefore, if a violation alleged under R.C. 4731.22 relates to the compliance of such an opinion with minimum medical standards, the State Medical Board is without jurisdiction to review the alleged violation.

However, there are other types of violations that do not relate specifically to medical standards but relate instead to the ethical nature of the physician's behavior. Some examples are:

> (4) Willfully betraying a professional confidence.
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> ...
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> (8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;
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> ...
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> (10) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;
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> ...
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> (12) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;
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> ...
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> (14) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;
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> ...
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> (17) Engaging in the division of fees for referral of patients, or the receiving of a thing of value in return for a specific referral of a patient to utilize a particular service or business;
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> (18) Subject to section 4731.226 [4731.22.6] of the Revised Code, violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The individual whose certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to the individual's profession.

...

> (20) Except when civil penalties are imposed under section 4731.225 [4731.22.5] or 4731.281 [4731.28.1] of the Revised Code, and subject to section 4731.226 [4731.22.6] of the Revised Code, violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board.
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> ...
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> (35) Failure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board at a deposition or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue.

R.C. 4731.22(B).

When the basis of a complaint relates to the practice of medicine, it appears that the State Medical Board would not have jurisdiction if the action occurred in connection with utilization review, because the action would not be considered the practice of medicine. *See, e.g.*, R.C. 4731.22(B)(8); R.C. 4731.22(B)(12). However, when the basis of a complaint is not restricted to the practice of medicine but pertains to the general character or actions of the physician in any setting, the State Medical Board would have jurisdiction. *See, e.g.*, R.C. 4731.22(B)(10); R.C. 4731.22(B)(14); *see generally Roy v. Ohio State Med. Bd.*, 80 Ohio App. 3d 675, 610 N.E.2d 562 (Franklin County 1992); 1994 Op. Att'y Gen. No. 94-052.

The answer to your third question thus depends upon the nature of the complaint. Pursuant to R.C. 1751.08(D), a physician's rendering of a medical necessity opinion during the course of utilization review conducted under R.C. Chapter 1751 is not considered the practice of medicine and is not subject to review by the State Medical Board as an act of medical practice; however, the physician remains subject to the jurisdiction of the State Medical Board under R.C. 4731.22 in other respects. *See* note 14, *supra*.

We are aware of instances in which courts of other jurisdictions have found that particular types of action taken by health insurance companies, or by physicians employed by those companies, may be subject to review by the appropriate medical board. In particular, the Court of Appeals of Arizona determined that the Arizona Board of Medical Examiners had jurisdiction to investigate complaints arising from medical pre-certification decisions made by a state-licensed physician who performed duties as the medical director of a health insurer. *Murphy v. Board of Medical Examiners*, 190 Ariz. 441, 949 P.2d 530 (Ct. App. 1997); *see also Morris v. District of Columbia Bd. of Med.*, 701 A.2d 364, 368 (D.C. App. 1997) (physician employed as vice president and medical director of insurance company had exclusively administrative duties and was not engaged in the practice of medicine; "on other facts a medical administrator of a health insurer ... which monitors and regularly questions treatment decisions by physicians" might be found to have practiced medicine). Further, the Attorney General of Louisiana recently found that health maintenance organizations in that state are subject to an order of the Louisiana State Board of Medical Examiners providing that the act of determining the necessity of proposed medical care so as to effect the

diagnosis or treatment of a patient is the practice of medicine and must be made by a licensed physician. La. Op. Att'y Gen. No. 98-491, 1999 WL 288869 (La.A.G.) (Apr. 27, 1999).

In contrast, Attorneys General of several states have concluded that activities of health insurance companies and their employees do not constitute the practice of medicine. For example, the Attorney General of the State of North Carolina concluded that pre-certification and utilization review activities of insurance companies do not constitute the practice of medicine, as follows:

> As a practical matter, a denial of third-party payment may have a direct impact upon the patient's decision of whether to undergo the treatment. However, such denial does not prohibit the patient from seeking other funding sources or from seeking treatment without third-party benefits, and it does not prohibit the attending physician from providing the treatment. The decision to forego or to continue medical treatment without third party reimbursement is made by the patient in consultation with his or her physician. Thus, *the person performing the utilization review is not diagnosing, operating on, prescribing for, administering to or treating any ailment, injury or deformity, but is merely deciding whether or not third-party payment is available.*

60 N.C. Op. Att'y Gen. 100, 1992 WL 525113 (N.C.A.G.) (Apr. 6, 1992) (emphasis added); *see* XXIV Kan. Op. Att'y Gen. 49, Op. No. 90-130, 1990 WL 547153 (Kan.A.G.) (Nov. 28, 1990) (stating that, in the utilization review process, "[c]are is not being administered or withheld by the reviewing person. Rather, a determination is made as to whether or not the proposed care is believed covered by the insurance contract. An insured who is denied benefits by utilization review, on the grounds that the treatment sought is not 'medically necessary' for example, is not prevented from obtaining medical care; such person would merely be in the same position as one without any insurance coverage at all"); *see also* Ark. Op. Att'y Gen. No. 90-104, 1990 WL 358803 (Ark.A.G.) (May 10, 1990) (out-of-state review of claims for chiropractic services does not constitute practice of chiropractic in Arkansas); Miss. Op. Att'y Gen. No. 93-0088, 1993 WL 207359 (Miss.A.G.) (May 18, 1993) (out-of-state utilization review does not constitute practice of medicine in Mississippi). *See generally Varol v. Blue Cross and Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989).[15]

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[15] Under the federal medicare and medicaid programs, decisions relating to utilization review or other cost and quality contract measures have been found to be separate from the practice of medicine and not to interfere with the practice of medicine. *See Szekely v. Florida Med. Ass'n*, 517 F.2d 345, 350 (5th Cir. 1975) ("[p]ermitting HEW to recoup funds paid out for medically unnecessary services does not constitute impermissible supervision of the practice of medicine .... The only issue posed by recoupment ... is whether the government should pay for the services provided"), *cert. denied*, 425 U.S. 960 (1976); *Association of Am. Physicians and Surgeons v. Weinberger*, 395 F. Supp. 125, 132-34 (N.D. Ill.) ("[t]he statute ... does not bar physicians from practicing their profession but only 'provides standards for the dispensation of Federal funds' .... [It] does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of his professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the federal government he is required to comply with certain guidelines and procedures enumerated in the statute"), *aff'd sub nom. Association of Am. Physicians and*

The authorities discussed above were decided under the law of their respective jurisdictions and are not determinative of Ohio law. Rather, as discussed above, Ohio law provides that actions taken by a health insuring corporation are not considered to constitute the practice of medicine. In issuing this opinion, we are construing existing Ohio statutes according to their terms to carry out the evident intent of the General Assembly. Should the General Assembly wish to modify the existing statutory provisions, it could do so through appropriate legislation.

Therefore, it is my opinion, and you are advised, as follows:

1. Pursuant to R.C. 1751.08(D), the rendering of an opinion as to the medical necessity of physician medical services for purposes of utilization review as defined in R.C. 1751.77(N) and governed by R.C. 1751.77-.86 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731.

2. Pursuant to R.C. 1751.08(D), the rendering of an opinion by a physician as to the medical necessity of physician medical services during an appeal of an adverse determination conducted under R.C. Chapter 1751 is not considered to be the practice of medicine and does not come within the regulatory, investigatory, or enforcement authority of the State Medical Board under R.C. Chapter 4731.

3. Pursuant to R.C. 1751.08(D), a physician's rendering of a medical necessity opinion during the course of utilization review conducted under R.C. Chapter 1751 is not considered to be the practice of medicine and is not subject to review by the State Medical Board as an act of medical practice; however, the physician remains subject to the jurisdiction of the State Medical Board under R.C. 4731.22 in other respects.

Surgeons v. Mathews, 423 U.S. 975 (1975); *see also Goodman v. Sullivan*, 891 F.2d 449 (2d Cir. 1989).