

TOIS: H15I & G Individual and Group Health – Hospital/Surgical/Medical Expense H16I & G Individual and Group Health – Major Medical
HOrg02 I & G Individual and Group Health Organizations – Health Maintenance (HMO) (Ohio HIC)

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
<p>Internal and external reviews – <u>for Health Insuring Corporations only</u></p>	<p>ORC 1751.811</p>	<p>In lieu of conducting a prospective, concurrent, or retrospective review under section 1751.81 of the Revised Code, providing a reconsideration under section 1751.82 of the Revised Code, or conducting an internal review under section 1751.83 of the Revised Code, a health insuring corporation may afford an enrollee an opportunity for an external review under section 3922.08 or 3922.10 of the Revised Code. If an external review is conducted pursuant to this section, the health insuring corporation is not required to afford the enrollee an opportunity for any of the reviews that were disregarded pursuant to this section, including the external review that may have resulted from a review that was disregarded pursuant to this section, unless new clinical information is submitted to the health insuring corporation.</p>
<p>Review of final determination, notice</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.03(B)(C)</p>	<p>(B) Review of a final adverse benefit determination shall be through an external review under section 3922.08, 3922.09, or 3922.10 of the Revised Code.</p> <p>(C) All health plan issuers shall provide notice to covered persons, pursuant to and in accordance with federal regulations, of all internal appeal processes, external review processes, the availability of any applicable office of health insurance assistance, ombudsman program, or other similar program in this state to assist consumers.</p>
<p>Reconsideration by issuer</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.06</p>	<p>Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, an independent review organization shall forward upon receipt a copy of any information received from a covered person pursuant to division (D)(1) of section 3922.05 of the Revised Code, as well as any other information received from the covered person, to the health plan issuer.</p> <p>Upon receipt of that information or the information described in division (K) of section 3922.10 of the Revised Code, a health plan issuer may reconsider its adverse benefit determination and provide coverage for the health service in question.</p> <p>Reconsideration of an adverse benefit determination by a health plan issuer based upon receipt of information under this section shall not delay or terminate an external review.</p> <p>If a health plan issuer reverses an adverse benefit determination under this section, the health plan issuer shall notify, in writing and within one business day of making such a decision, the covered person, the assigned independent review organization, and the superintendent of insurance.</p> <p>Upon receipt of such a notification, the assigned independent review organization shall terminate the associated external review.</p>

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<p>Provisions applicable to standard reviews – HPI information to IRO, IRO reversal</p> <p><u>See definitions in ORC 3922.01</u></p>	ORC 3922.08	<p>(A) The provisions of this section apply only to standard reviews, which are not expedited and do not involve an experimental or investigational treatment.</p> <p>(B) Within five days after the receipt of a request for an external review that is complete and valid, the health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination.</p> <p>(C) An external review shall not be delayed due to failure on the part of the health plan issuer to provide the information required under division (B) of this section.</p> <p>(D)(1) An independent review organization may reverse an adverse benefit determination if the information required under division (B) of this section is not provided in the allotted time. The independent review organization may also grant a request from the health plan issuer for more time to provide the required information.</p> <p>(2) If an adverse benefit determination is reversed under division (D)(1) of this section, the independent review organization shall notify, within one business day of making the decision, the covered person, the health plan issuer, and the superintendent of insurance.</p>
<p>Provisions applicable to external reviews involving experimental or investigational treatment – Documents to the IRO</p> <p><u>See definitions in ORC 3922.01</u></p>	ORC 3922.10 (D)	<p>(D) The health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination within whichever of the following applies:</p> <p>(1) Within five days after the receipt of a request for a standard external review;</p> <p>(2) For an expedited external review, immediately electronically, or by facsimile or any other available expeditious method.</p>
<p>Provisions applicable to external reviews involving experimental or investigational treatment – Conflict, HPI failure, reversal of</p>	ORC 3922.10 (G)(I)(J)	<p>(G) Neither the covered person, nor the health plan issuer, shall choose or have any influence over the choice of the clinical reviewer or reviewers chosen under division (E) of this section.</p> <p>(I) An external review shall not be delayed due to failure on the part of the health plan issuer to provide the information required under division (D) of this section.</p>

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decision <u>See definitions in ORC 3922.01</u>		<p>(J)(1) An independent review organization may reverse an adverse benefit determination, if the information required under division (D) of this section is not provided in the allotted time. The independent review organization may also grant a request from the health plan issuer for more time to provide the required information.</p> <p>(2) If an adverse benefit determination is reversed under division (J)(1) of this section, the independent review organization shall immediately notify the covered person, the health plan issuer, and the superintendent of insurance.</p>
Provisions applicable to external reviews involving experimental or investigational treatment – Information to HPI <u>See definitions in ORC 3922.01</u>	ORC 3922.10 (L)	(L) Within one business day after the receipt of any such information submitted by the covered person in accordance with division (K)(1) of this section, the independent review organization shall forward the information to the health plan issuer. Upon receipt of any such forwarded information in accordance with division (K)(1) of this section, a health plan issuer may reconsider its adverse benefit determination as described in section 3922.06 of the Revised Code.
Maintenance of records; reports <u>See definitions in ORC 3922.01</u>	ORC 3922.17 (B)	(B) A health plan issuer shall maintain written records on all requests made for an external review under this chapter and shall provide all such information as required by any associated rules, policies, or procedures adopted by the superintendent of insurance. A health plan issuer shall maintain written records on all requests for external review for at least three years.
Disclosure of external review procedures – ABD notification <u>See definitions in ORC 3922.01</u>	ORC 3922.19 (C)(D)	<p>(C)(1) When a health plan issuer notifies a covered person of an adverse benefit determination, the health plan issuer shall also notify the covered person, in writing, of the covered person's right to request an external review, pursuant to section 3922.08, 3922.09, 3922.10, or 3922.11 of the Revised Code.</p> <p>(2) As part of the written notice required under division (C)(1) of this section, a health plan issuer</p>

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		<p>shall include all of the following:</p> <p>(a) Information sufficient to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;</p> <p>(b) A description of the reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;</p> <p>(c) A description of the health plan issuer's standard, if any, that was used in making the determination;</p> <p>(d) A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal and an external review;</p> <p>(e) Disclosure of the availability of assistance from the superintendent with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the superintendent's office of consumer services.</p> <p>(3) In the case of a notice of a final adverse benefit determination subsequent to an internal appeal, in addition to the information required under division (C)(2) of this section, the notice must also include a discussion of the decision.</p> <p>(4) Any written notice provided under division (C) of this section shall be in a form prescribed by the superintendent of insurance.</p> <p>(D) For an adverse benefit determination that is not a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:</p> <p>(1) If the covered person's treating physician certifies in writing that the covered person has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the</p>

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		<p>covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.</p> <p>(2) If the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse benefit determination would be significantly less effective if not promptly initiated, the covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 or 3922.10 of the Revised Code.</p> <p>(3) If the covered person has requested an internal appeal and the health plan issuer has not issued a written decision to the covered person within thirty days following the date the covered person files the request, and the covered person has not requested or agreed to a delay, the covered person may file a request for external review pursuant to section 3922.08 of the Revised Code and may be considered to have exhausted the health plan issuer's internal appeals process for purposes of section 3922.04 of the Revised Code.</p>
<p>Disclosure of external review procedures – final ABD notification, additional information</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.19 (E)(F)</p>	<p>(E) For a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:</p> <p>(1) A written request for an external review must be submitted to the health plan issuer within one hundred eighty days after the date of the notice of final adverse benefit determination.</p> <p>(2) If the covered person's treating physician certifies in writing that the covered person has a medical condition for which the time frame for completion of a standard external review pursuant to section 3922.08 of the Revised Code would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review pursuant to section 3922.09 of the Revised Code.</p>

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		<p>(3)(a) If the final adverse benefit determination concerns a health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person may request an expedited external review pursuant to section 3922.09 of the Revised Code.</p> <p>(b) If the final adverse benefit determination concerns denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person may file a request for an external review to be conducted pursuant to section 3922.10 of the Revised Code, or if the covered person's treating physician certifies in writing that the recommended or requested health care service that is the subject of the request would be significantly less effective if not promptly initiated, the covered person may request an expedited external review to be conducted under section 3922.10 of the Revised Code.</p> <p>(F)(1) In addition to any information required to be provided under divisions (D) and (E) of this section, the health plan issuer shall include a description of both the standard and expedited external review procedures the health plan issuer is required to produce pursuant to this chapter, highlighting in the external review procedures the sections of the Revised Code that give the covered person the opportunity to submit additional information.</p> <p>(2) The health plan issuer shall also include any forms used to process an external review, including an authorization form, or other document approved by the superintendent that complies with the requirements of 45 C.F.R. 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health plan issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are related in any manner to the external review.</p>
Admissibility of written decision or medicare reimbursement standards	ORC 3922.20	Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under this chapter shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate

Chapter 3922 External Review - all applicable products - Filing Guidance – COMPLIANCE CONFIRMATION

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<u>See definitions in ORC 3922.01</u>		<p>description of the state of medical knowledge at the time it was written.</p> <p>Consistent with the Rules of Evidence, any party to a civil action related to a plan's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.</p>