

Chapter 3922 External Review - all applicable products - Filing Guidance – FORM REVIEW REQUIREMENTS

TOIS: H15I & G Individual and Group Health – Hospital/Surgical/Medical Expense H16I & G Individual and Group Health – Major Medical
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REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
Request for review of adverse benefit determination <u>See definitions in ORC 3922.01</u>	ORC 3922.02	<p>(A) A covered person may make a request for an external review of an adverse benefit determination.</p> <p>(B) All requests for external review shall be made in writing, including by electronic means, by the covered person to the health plan issuer within one hundred eighty days of the date of the final adverse benefit determination . However, in the case of an expedited external review under section 3922.09 of the Revised Code, the review may be requested orally .</p> <p>(C) An adverse benefit determination shall be eligible for internal appeal or external review, regardless of the cost of the requested health care service related to the adverse benefit determination .</p>
Internal appeal process <u>See definitions in ORC 3922.01</u>	ORC 3922.03 (A)	<p>(A) All health plan issuers shall implement an internal appeal process under which a covered person may appeal an adverse benefit determination. This process must be in compliance with the "Patient Protection and Affordable Care Act of 2010," Pub. L. 111-148, 124 Stat. 119, as amended, and the associated regulations, as well as any other applicable state laws or rules or federal regulations.</p>
Exhaustion of issuer's internal appeal process <u>See definitions in ORC 3922.01</u>	ORC 3922.04	<p>(A) Except as provided in division (E) of this section, a health plan issuer is not required to grant a request for a standard external review made under section 3922.08 or 3922.10 of the Revised Code until the covered person has exhausted the health plan issuer's internal appeal process.</p> <p>(B) An internal appeal process shall be considered exhausted if a covered person has requested an internal appeal and has not received a written decision from the health plan issuer within the time frame required by 29 C.F.R. 2560.503-1 or the health plan issuer fails to adhere to all requirements of the internal appeals process.</p> <p>(C) Notwithstanding division (B) of this section, the internal appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person so long as the health plan issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health plan issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health plan issuer and the covered person, and is not reflective of a pattern or practice of noncompliance, except that:</p> <p>(1) If the health plan issuer denies a request for external review under this division, the covered person may request written explanation from the health plan issuer, and the health plan issuer shall provide the explanation within ten days, including a specific description of its basis, if any, for asserting that the delay should not cause the internal appeals process to be considered</p>

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		<p>exhausted;</p> <p>(2) The covered person may request review by the superintendent of the health plan issuer's explanation provided under division (C)(1) of this section and if the superintendent affirms the health plan issuer's explanation, the covered person may, within ten days of the superintendent's notice of decision, resubmit and pursue the internal appeal process. Time periods for refiling the internal appeal shall begin to run upon receipt of such notice by the covered person.</p> <p>(D) Notwithstanding division (B) of this section, a covered person shall not make a request for an external review of an adverse benefit determination involving a retrospective review determination made pursuant to a utilization review until the covered person has exhausted the health plan issuer's internal appeals process.</p> <p>(E) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health plan issuer's internal appeals procedures whenever the health plan issuer agrees to waive the exhaustion requirement. If the internal appeal process is waived, the covered person may file a request in writing for a standard external review under section 3922.08 or 3922.10 of the Revised Code.</p> <p>(F) Notwithstanding any other section in this chapter, health plan issuers offering individual health insurance coverage, including coverage offered to individuals through nonemployer groups shall not require more than one level of internal appeal before the individual may request an external review.</p>
<p>Opportunities for external review by independent review organization (IRO)</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.05 (A)(B)(C)</p>	<p>(A) A health plan issuer shall afford the opportunity for an external review by an independent review organization for an adverse benefit determination if the determination involved a medical judgment or if the decision was based on any medical information, pursuant to the following sections:</p> <p>(1) Section 3922.08 of the Revised Code for a standard review;</p> <p>(2) Section 3922.09 of the Revised Code for an expedited review;</p> <p>(3) Section 3922.10 of the Revised Code for reviews involving experimental procedures.</p> <p>(B) A health plan issuer shall afford the opportunity for an external review by the superintendent of insurance for an adverse benefit determination by the health plan issuer based on a contractual issue that did not involve a medical judgment or any medical information, pursuant to section 3922.11 of the Revised Code.</p> <p>(C) For an adverse benefit determination in which emergency medical services have been determined to be not medically necessary or appropriate after an external review pursuant to</p>

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		division (A) of this section, the health plan issuer shall afford the covered person the opportunity for an external review by the superintendent of insurance, based on the prudent layperson standard, pursuant to section 3922.11 of the Revised Code.
Health plan issuer (HPI) procedures to initiate review <u>See definitions in ORC 3922.01</u>	ORC 3922.05 (D)	<p>(D) Upon receipt of a request for an external review from a covered person, the health plan issuer shall review it for completeness as prescribed under any associated rules, policies, or procedures adopted by the superintendent.</p> <p>(1) If the request is complete, the health plan issuer shall initiate an external review in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance and shall notify the covered person in writing, in a form specified by the superintendent of insurance, that the request is complete. This notification shall include both of the following:</p> <p>(a) The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information;</p> <p>(b) Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, a statement that the covered person may, within ten business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.</p> <p>(2) If the request for an external review is not complete, the health plan issuer shall, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, inform the covered person in writing, including what information is needed to make the request complete.</p>
Request denial and opportunity for review of decision by superintendent <u>See definitions in ORC 3922.01</u>	ORC 3922.05 (E)(F)	<p>(E)(1) If the health plan issuer denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the health plan issuer shall notify the covered person in writing of both of the following:</p> <p>(a) The reason for the denial;</p> <p>(b) That the denial may be appealed to the superintendent.</p> <p>(2) If the health plan issuer denies a request for external review on the basis that the adverse benefit determination is not eligible for an external review, the covered person may appeal the</p>

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		<p>denial to the superintendent of insurance.</p> <p>(3) Regardless of a determination made by a health plan issuer, the superintendent of insurance may determine that a request is eligible for external review. The superintendent's determination shall be made in accordance with the terms of the covered person's benefit plan and shall be subject to all applicable provisions of this chapter.</p> <p>(F)(1) If an external review of an adverse benefit determination is granted, the superintendent, according to any rules, policies, or procedures adopted by the superintendent shall assign an independent review organization from the list of organizations maintained by the superintendent under section 3922.13 of the Revised Code to conduct the external review and shall notify the health plan issuer of the name of the assigned independent review organization.</p> <p>(2) The assignment of an approved independent review organization shall be done on a random basis from those independent review organizations qualified to conduct the review in question based on the nature of the health care service that is the subject of the adverse benefit determination.</p> <p>(3) The superintendent of insurance shall not choose an independent review organization with a conflict of interest, as prescribed under section 3922.14 of the Revised Code.</p>
<p>IRO consideration and notice requirements</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.05 (G)(H)</p>	<p>(G) In its review of an adverse benefit determination under section 3922.08, 3922.09, or 3922.10 of the Revised Code, an assigned independent review organization is not bound by any decisions or conclusions reached by the health plan issuer during its utilization review process or internal appeals process. The organization is not required to, but may, accept and consider additional information submitted after the end of the ten-business-day period described in division (D)(1)(b) of this section.</p> <p>(H)(1) An independent review organization assigned to review an adverse benefit determination shall provide written notice of its decision to either uphold or reverse the determination within thirty days of receipt by the health plan issuer of a request for a standard review or a standard review involving an experimental or investigational treatment, or within seventy-two hours of receipt by the health plan issuer of an expedited request.</p> <p>(2) The written notice shall be sent to all of the following:</p> <p>(a) The covered person;</p>

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		<p>(b) The health plan issuer;</p> <p>(c) The superintendent of insurance.</p> <p>(3) The written notification shall include all of the following:</p> <p>(a) A general description of the reason for the request for external review;</p> <p>(b) The date the independent review organization was assigned by the superintendent of insurance to conduct the external review;</p> <p>(c) The dates over which the external review was conducted;</p> <p>(d) The date on which the independent review organization's decision was made;</p> <p>(e) The rationale for its decision;</p> <p>(f) References to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision.</p> <p>(l) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.</p>
<p>Information considered for review</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.07</p>	<p>In addition to the information provided under division (D)(1)(b) of section 3922.05, division (B) of section 3922.08, division (C) of section 3922.09, and division (D) of section 3922.10 of the Revised Code, an assigned independent review organization, to the extent that such documents are available and appropriate, shall consider all of the following when conducting its review:</p> <p>(A) The covered person's medical records;</p> <p>(B) The attending health care professional's recommendation;</p> <p>(C) Consulting reports from appropriate health care professionals and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;</p> <p>(D) The terms of coverage under the covered person's health benefit plan to ensure that the</p>

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		<p>independent review organization's decision is not contrary to the terms of the plan;</p> <p>(E) The most appropriate practice guidelines, including evidence-based standards, and practice guidelines developed by the federal government, and national or professional medical societies, boards, and associations;</p> <p>(F) Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization;</p> <p>(G) The opinion of the independent review organization's clinical reviewer or reviewers after considering the other sources described in this section.</p>
<p>Request for expedited external review</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.09</p>	<p>(A) A covered person may make a request for an expedited external review, except as provided in division (I) of this section:</p> <p>(1) After an adverse benefit determination, if both of the following apply:</p> <p>(a) The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of an expedited internal appeal;</p> <p>(b) The covered person has filed a request for an expedited internal appeal.</p> <p>(2) After a final adverse benefit determination, if either of the following apply:</p> <p>(a) The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of a standard external review;</p> <p>(b) The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.</p> <p>(B) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division (A) of this section. The health plan issuer shall immediately notify the covered person of</p>

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		<p>its determination in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.</p> <p>(C) If a request for an expedited review is complete and eligible, the health plan issuer shall immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization electronically, or by facsimile or other available expeditious method.</p> <p>(D) In addition to the information transmitted under division (C) of this section, the assigned independent review organization shall also consider relevant information as required under section 3922.07 of the Revised Code.</p> <p>(E) As expeditiously as the covered person's medical condition requires, but no more than seventy-two hours after receipt by the health plan issuer of a request for an expedited, external review, the assigned independent review organization shall uphold or reverse the adverse benefit determination.</p> <p>(F) If a health plan issuer fails to provide the documents and information as required in division (C) of this section, the independent review organization shall not delay the external review and may accordingly reverse the adverse benefit determination.</p> <p>(G) An independent review organization shall promptly notify the covered person, health plan issuer, and superintendent of insurance of any decision made under this section. If such a notice is not made in writing, the independent review organization, shall provide, within forty-eight hours of making the decision, written confirmation, including the information required under division (H)(3) of section 3922.05 of the Revised Code, of its decision to the covered person, the health plan issuer, and the superintendent of insurance.</p> <p>(H) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.</p> <p>(I) An expedited, external review may not be provided for retrospective final adverse benefit determinations.</p>
<p>Provisions applicable to external reviews involving experimental or</p>	<p>ORC 3922.10 (A)(B) (C)</p>	<p>The provisions of this section apply only to external reviews that involve an experimental or investigational treatment.</p> <p>(A) A covered person may request an external review of an adverse benefit determination based on the conclusion that a requested health care service is experimental or investigational, except</p>

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<p>investigational treatment – Eligibility and request method</p> <p><u>See definitions in ORC 3922.01</u></p>		<p>when the requested health care service is explicitly listed as an excluded benefit under the covered person's benefit plan.</p> <p>(B) To be eligible for an external review under this section, a covered person's treating physician shall certify that one of the following situations is applicable:</p> <p>(1) Standard health care services have not been effective in improving the condition of the covered person.</p> <p>(2) Standard health care services are not medically appropriate for the covered person.</p> <p>(3) There is no available standard health care service covered by the health plan issuer that is more beneficial than the requested health care service.</p> <p>(C)(1) A covered person may request orally or by electronic means an expedited review under this section if the person's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.</p> <p>(2) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division (C)(1) of this section. The health plan issuer shall immediately notify the covered person of its determination in accordance with any associated rules adopted by the superintendent of insurance.</p>
<p>Provisions applicable to external reviews involving experimental or investigational treatment – IRO opinion</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.10 (H)</p>	<p>(H)(1) Each chosen clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the adverse benefit determination should be upheld or reversed.</p> <p>(2) In reaching such opinions, a clinical reviewer is not bound by any conclusions reached by the health plan issuer during a utilization review process or its internal appeals process.</p> <p>(3) Any such opinion shall be in writing and shall include all of the following information:</p> <p>(a) A description of the covered person's condition;</p> <p>(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to the covered person than any available standard health care service, and that the</p>

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		<p>adverse risks of the requested health care service would not be substantially greater than those of available standard health care services;</p> <p>(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;</p> <p>(d) A description and analysis of any evidence-based standard considered;</p> <p>(e) Information on whether the reviewer's rationale for the opinion is based on division (K)(2)(b) or (c) of this section.</p>
<p>Provisions applicable to external reviews involving experimental or investigational treatment – IRO decision and notice</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.10(M)(N)</p>	<p>(M)(1) Within thirty days after the date of receipt by the health plan issuer of a request for a standard external review, or within seventy-two hours of receipt by the health plan issuer of a request for an expedited external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to the covered person, the health plan issuer, and the superintendent of insurance.</p> <p>(2)(a) If a majority of the clinical reviewers recommend that the requested health care service should be covered, the independent review organization shall make a decision to reverse the health plan issuer's adverse benefit determination.</p> <p>(b) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health plan issuer's adverse benefit determination.</p> <p>(c)(i) If the clinical reviewers are evenly split as to whether the adverse benefit determination should be reversed or upheld, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to this division.</p> <p>(ii) The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to this section.</p> <p>(iii) The selection of the additional clinical reviewer under this division shall not extend the time within which the assigned independent review organization is required to make a decision.</p> <p>(3) The independent review organization shall include in the notice provided pursuant to division</p>

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		<p>(M)(1) of this section all of the following:</p> <p>(a) A general description of the reason for the request for external review;</p> <p>(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for that recommendation;</p> <p>(c) The date the independent review organization was assigned by the superintendent to conduct the external review;</p> <p>(d) The dates over which the external review was conducted;</p> <p>(e) The date of its decision;</p> <p>(f) The principal reason or reasons for its decision;</p> <p>(g) The rationale for its decision.</p> <p>(N) Upon receipt of a notice of a decision by an independent review organization pursuant to division (M)(1) of this section reversing the adverse benefit determination, a health plan issuer shall immediately provide coverage of the requested health care service in question.</p>
<p>Review by superintendent of insurance</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.11</p>	<p>(A) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for external review for adverse benefit determinations where the determination by the health plan issuer was based on a contractual issue and did not involve a medical judgment or a determination based on any medical information, except for emergency services, as specified in division (C) of section 3922.05 of the Revised Code.</p> <p>(B) A health plan issuer shall submit a request for external review pursuant to division (B) or (C) of section 3922.05 of the Revised Code to the superintendent, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.</p> <p>(C) On receipt of a request from a health plan issuer, the superintendent shall consider whether the health care service is a service covered under the terms of the covered person's policy, contract, certificate, or agreement, except that the superintendent shall not conduct a review under this section unless the covered person has exhausted the health plan issuer's internal appeal process, pursuant to sections 3922.03 and 3922.04 of the Revised Code. The health plan issuer and covered person shall provide the superintendent with any information required by the</p>

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		<p>superintendent that is in their possession and is germane to the review.</p> <p>(D) Unless the superintendent is not able to do so because making the determination requires a medical judgement or a determination based on medical information, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the covered person's contract, policy, certificate, or agreement. The superintendent shall notify the covered person and the health plan issuer of the superintendent's determination.</p> <p>(E) If the superintendent notifies the health plan issuer that making the determination requires a medical judgement or a determination based on medical information, the health plan issuer shall initiate an external review under this chapter.</p> <p>(F) If the superintendent determines that the health service is a covered service, the health plan issuer shall cover the service.</p> <p>(G) If the superintendent determines that the health care service is not a covered service, the health plan issuer is not required to cover the service or afford the covered person an external review by an independent review organization.</p>
<p>Effect of decision</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.12</p>	<p>(A) An external review decision is binding on the health plan issuer except to the extent the health plan issuer has other remedies available under applicable state law, or unless the superintendent of insurance determines that, due to the facts and circumstances of an external review, a second external review is required.</p> <p>(B) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law, or unless the superintendent determines that, due to the facts and circumstances of an external review, a second external review is required.</p> <p>(C) A covered person may not file a subsequent request for external review involving the same adverse benefit determination for which the covered person has already received an external review decision pursuant to this chapter, except in the event that new medical or scientific evidence is submitted to the health plan issuer.</p>
<p>Payment of costs</p> <p><u>See definitions in ORC 3922.01</u></p>	<p>ORC 3922.18</p>	<p>The health plan issuer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the external review, including the cost of any external review that is required at the direction of the superintendent.</p> <p>If the superintendent determines that, due to the facts and circumstances of an external review, a</p>

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		second external review is required, the health plan issuer shall pay the costs of the second review.
Disclosure of external review procedures – description of procedure <u>See definitions in ORC 3922.01</u>	ORC 3922.19 (A)(B)	<p>(A) Each health plan issuer shall include a description of its external review procedures, including the superintendent’s contractual review, in, or attached to, the policy, certificate, membership booklet, or outline of coverage, or other evidence of coverage it provides to covered persons. This disclosure shall be in a form prescribed by the superintendent in any associated rules, policies, or procedures.</p> <p>(B) The disclosure required by division (A) of this section shall include a statement that informs the covered person of the covered person’s right to file a request for an external review of an adverse benefit determination with the health plan issuer. The statement shall do all of the following:</p> <p>(1) Explain that external review is available when the adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, and level of care or effectiveness;</p> <p>(2) Include the telephone number and address of the superintendent;</p> <p>(3) Inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of the covered person’s medical records as necessary to conduct the external review.</p>
Disclosure of external review procedures – exhaustion of internal appeal process <u>See definitions in ORC 3922.01</u>	ORC 3922.19 (D)(3)	<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>