Ohio Revised Code

Section 3922.04 Exhaustion of issuer's internal appeal process.

Effective: September 6, 2012
Legislation: House Bill 341 - 129th General Assembly

(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.

(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.

(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:

(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 exhausted;

(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.

(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.

(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.

(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.