Ohio Revised Code

Section 3922.10 Provisions applicable to external reviews involving experimental or investigational treatment; timing.

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

The provisions of this section apply only to external reviews that involve an experimental or investigational treatment.

(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 when the requested health care service is explicitly listed as an excluded benefit under the covered person's benefit plan.

(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:

(1) Standard health care services have not been effective in improving the condition of the covered person.

(2) Standard health care services are not medically appropriate for the covered person.

(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.

(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.

(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.

(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:

(1) Within five days after the receipt of a request for a standard external review;

(2) For an expedited external review, immediately electronically, or by facsimile or any other available expeditious method.

(E) An independent review organization assigned by the superintendent of insurance under division (F) of section 3922.05 of the Revised Code shall do both of the following:

(1) Select at least one clinical reviewer, pursuant to divisions (F) and (G) of this section to conduct the external review;

(2) Make a decision to uphold or reverse the adverse benefit determination based upon the opinion of the clinical reviewer or reviewers.

(F) In selecting clinical reviewers under division (E) of this section, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 3922.15 of the Revised Code.

(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.

(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.

(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.

(3) Any such opinion shall be in writing and shall include all of the following information:

(a) A description of the covered person's condition;

(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 adverse risks of the requested health care service would not be substantially greater than those of available standard health care services;

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard considered;

(e) Information on whether the reviewer's rationale for the opinion is based on division (K)(2)(b) or (c) of this section.

(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.

(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.

(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.

(K)(1) Each clinical reviewer shall review all of the information received pursuant to division (D) of this section, as well as any other information submitted in writing by the covered person pursuant to division (D) of section 3922.05 of the Revised Code.

(2) In addition to the documents and information provided pursuant to division (D) of this section and division (D) of section 3922.05 of the Revised Code, each clinical reviewer shall consider the following:

(a) Information required under section 3922.07 of the Revised Code;

(b) Whether the requested health care service has been approved by the federal food and drug administration, if applicable, for the condition;

(c) Whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested health care service is more likely than not to be beneficial to the covered person than any available standard health care service, and that the adverse risks of the requested health care service would not be substantially greater than those of available standard health care services.

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(3) The independent review organization shall include in the notice provided pursuant to division (M)(1) of this section all of the following:

(a) A general description of the reason for the request for external review;

(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;

(c) The date the independent review organization was assigned by the superintendent to conduct the external review;

(d) The dates over which the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision;

(g) The rationale for its decision.

(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.