Ohio Revised Code

Section 3922.19 Disclosure of external review procedures.

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

(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.

(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:

(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;

(2) Include the telephone number and address of the superintendent;

(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.

(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.

(2) As part of the written notice required under division (C)(1) of this section, a health plan issuer shall include all of the following:

(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;

(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;

(c) A description of the health plan issuer's standard, if any, that was used in making the determination;

(d) A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal and an external review;

(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.

(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.

(4) Any written notice provided under division (C) of this section shall be in a form prescribed by the superintendent of insurance.

(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:

(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 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.

(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.

(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.

(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:

(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.

(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.

(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.

(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.

(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.

(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.