Ohio Revised Code

Section 3922.05 Opportunities for external review by independent review organization.

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

(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:

(1) Section 3922.08 of the Revised Code for a standard review;

(2) Section 3922.09 of the Revised Code for an expedited review;

(3) Section 3922.10 of the Revised Code for reviews involving experimental procedures.

(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.

(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 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.

(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.

(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:

(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;

(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.

(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.

(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:

(a) The reason for the denial;

(b) That the denial may be appealed to the superintendent.

(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 denial to the superintendent of insurance.

(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.

(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.

(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.

(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.

(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.

(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.

(2) The written notice shall be sent to all of the following:

(a) The covered person;

(b) The health plan issuer;

(c) The superintendent of insurance.

(3) The written notification shall include all of the following:

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

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

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

(d) The date on which the independent review organization's decision was made;

(e) The rationale for its decision;

(f) References to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision.

(I) 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.