ODI
Ohio Department of Insurance

John R. Kasich, Governor
Mary Taylor, Lt. Governor/Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658
www.insurance.ohio.gov

November 11, 2011

TO: Ohio Health Plan Issuers

In preparation for compliance with new federal external review requirements, Ohio recently enacted Substitute House Bill 218 to be effective December 26, 2011. This new legislation pertains to all requests for external review of an adverse benefit determination submitted on or after January 1, 2012 and will apply to both grandfathered and non-grandfathered plans, regardless of date(s) of service. All health plan issuers, as defined in newly codified ORC §3922.01 (P) and regulated under ORC Chapters 17 and 39, must submit revised internal appeal and external review contract language for approval in accordance with ORC §3923.02. The link to Sub. H. B. 218 is shown below. http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_218

Last month, Ohio requested a re-determination of the state external review process. On October 26, 2011, CCIIO confirmed Sub. H. B. 218 meets the standards of the NAIC parallel process. This is a final determination; therefore health plan issuers must continue to comply with the Ohio external review process.

In addition to incorporating required federal changes, Ohio was able to maintain some enhanced features of the previous external review process. Some notable features of the revised external review process are shown in the attached External Review Revision Highlights. Please be sure to review Sub. H. B. 218 in its entirety for a complete picture of all required revisions.

In accordance with ORC §3922.03 and effective January 1, 2012, Ohio will require all health plan issuers of both grandfathered and non-grandfathered plans to implement an internal appeal process that complies with federal law. This standard requires compliance with the Department of Labor Claims Procedure Regulation dated November 2000; the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under PPACA dated July 2010; and, any subsequent regulations or guidance released.

A summary of the complete Ohio Appeal Process is attached for your review. The summary provides a comprehensive overview of the new ORC Chapter 3922 along with the required federal changes to the DOL Claims Procedure Regulation. This document has been prepared to provide guidance only and is not intended to replace or alter any state or federal law.

If you have any questions or need additional information, please contact the Life & Health area of the Office of Product Regulation and Actuarial Services in the Ohio Department of Insurance at (614) 644-2644. Thank you.

External Review Revision Highlights

November 11, 2011

Code Reference	Enhancement
3922.03 C	Health plan issuers are required to provide effective written notice to covered persons of their right to external review.
3922.04	The internal appeal process must be exhausted prior to initiating an external review except in the following instances: • The health plan issuer agrees to waive the exhaustion requirement • The covered person did not receive a written decision of their internal appeal within the required time frame • The health plan issuer fails to meet all requirements of the internal appeal process unless the failure: o Was de minimis o Does not cause or is not likely to cause prejudice or harm to the covered person o Was for good cause and beyond the control of the health plan issuer o Is not reflective of a pattern or practice of non-compliance • An expedited external review is sought simultaneously with an expedited internal review
3922.02 C	There is no minimum dollar amount required in order to be eligible to request an internal appeal or external review.
3922.02 B	Ohio law continues to allow covered persons 180 days to file a request for external review after completion of the internal appeal process and receipt of the notice of adverse benefit determination.
3922.05 D, G and 3922.06	Health plan issuers are required to notify the covered person of the opportunity to submit, within 10 days after receipt of the notice, additional information to the IRO or superintendent for consideration when conducting an external review. The IRO will forward the information within 1 business day of receipt to the health plan issuer. Upon receipt, the health plan issuer may reconsider their adverse benefit determination and provide coverage for the health care service.
3922.05 H 3922.10 M	Ohio law continues to require the IRO to provide notice of its decision to uphold or reverse an adverse benefit determination within 30 days of receipt, by the health plan issuer, of the request for a standard external review.
3922.09	Notice of a decision to uphold or reverse the adverse benefit determination for an **expedited** external review must be provided as expeditiously as possible, but no later than 72 hours after receipt, by the health plan issuer, of the request for external review.

External Review Revision Highlights

November 11, 2011

Code Reference	Enhancement
3922.03 3922.19	Health plan issuers must provide a description of internal appeal and external review procedures in or attached to the policy, certificate or evidence of coverage provided to the covered person.
3922.10	Eligibility for an external review that involves an experimental or investigational treatment must be certified by the covered person's physician.
3922.18	Ohio will continue to require the health plan issuer to bear the cost of the external review.
3922.12	The IRO decision is binding on both the covered person and the health plan issuer. (except for other remedies under law)
3922.11	The covered person must contact the health plan issuer to initiate a request for external review by the superintendent.

Ohio Appeal Process

November 11, 2011

THE FOLLOWING INFORMATION PROVIDES AN OVERVIEW OF THE NEW OHIO APPEAL REQUIREMENTS. PLEASE NOTE THAT THIS SUMMARY IS NOT ALL INCLUSIVE. PLEASE REFER TO APPLICABLE FEDERAL AND STATE LAW FOR A COMPLETE PICTURE OF THE REQUIREMENTS.

General Information

The Ohio mandated appeal process consists of two steps:

1. Internal Appeal
2. External Review

A covered person or their authorized representative may appeal an adverse benefit determination or ABD. An ABD is a decision by the health plan issuer to do any of the following:

- deny, reduce or terminate a requested health care service or payment in whole or in part
- not issue health insurance coverage to an applicant in the individual and non-employer group markets
- rescind coverage under a health benefit plan

A covered person may request an appeal of any ABD, regardless of the actual or estimated cost of the health care service. The health plan issuer must notify the covered person of their right to an internal appeal and an external review as well as the availability of other programs that assist consumers. In addition, health plan issuers must provide a description of internal appeal and external review procedures in or attached to the policy, certificate or evidence of coverage provided to the covered person.

Exhaustion Requirements

A covered person must exhaust the internal appeal process prior to initiating an external review except in the following instances:

- the health plan issuer agrees to waive the exhaustion requirement
- the covered person did not receive a written decision of their internal appeal within the required time frame
- the health plan issuer fails to meet all requirements of the internal appeal process unless the failure:
    - was de minimis
    - does not cause or is not likely to cause prejudice or harm to the covered person

  - was for good cause and beyond the control of the health plan issuer
  - is not reflective of a pattern or practice of non-compliance
- an expedited external review is sought simultaneously with an expedited internal review

A covered person may not request an external review of an ABD involving a retrospective utilization review decision until the health plan issuer's internal appeal process has been exhausted unless the health plan issuer agrees to waive the exhaustion requirement.

In the event the health plan issuer denies a request for an external review because the internal appeal process has not been exhausted, the covered person may request an explanation from the health plan issuer. The health plan issuer must provide a written explanation within 10 days. The covered person may request a review of this explanation from the superintendent. If the superintendent upholds the health plan issuer's explanation, the covered person may resubmit the request to the health plan issuer for an internal appeal within 10 days. Time periods for re-filing the internal appeal shall begin upon receipt of the superintendent's notice.

Internal Appeal

All health plan issuers must provide an internal appeal process that allows a covered person to appeal an ABD. The internal appeal process must comply with any applicable state and federal law.

Federal Requirements

Under new federal law, health plan issuers are now required to comply with the DOL Claims Procedure Regulation dated November 2000. Federal regulations also revised the DOL Claims Procedure Regulation in the following ways:

- the definition of ABD has been expanded to include rescission
- health plan issuers must notify the covered person of an ABD for claims involving urgent care as soon as possible but no later than 72 hours after receipt of the claim
- health plan issuers must provide to the covered person, free of charge, any new or additional evidence considered and the rationale for the ABD
- new criteria were introduced to ensure health plan issuers avoid conflicts of interest with regard to claims and appeals adjudication
- established new standards for required notices to a covered person
- the covered person has the right to an external review if the health plan issuer fails to adhere to the internal appeal process with the previously noted exceptions

- the covered person has the right to continuation of coverage pending the outcome of the internal appeal
- concurrent internal appeal and external review must be allowed for an ongoing course of treatment involving urgent care
- the covered person has the right to appeal an initial eligibility determination in the individual and non-employer group markets
- only one level of internal appeal is permitted for the individual and non-employer group markets
- health plan issuers must maintain records of all internal appeal claims and notices

Concurrent Internal Appeal and External Review

A covered person in the process of an expedited internal appeal may request that an expedited external review be conducted simultaneously in either of the following instances:

- the covered person's treating physician certifies in writing that the ABD involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize their ability to regain maximum function if treated after the time frame of an expedited internal appeal
- in the case of experimental or investigational treatment, the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not initiated promptly

External Review

All health plan issuers must provide an external review process that allows a covered person to further appeal an ABD. The external review process must comply with any applicable state and federal law. Effective December 26, 2011, applicable state law can be found under O.R.C. Chapter 3922.

Opportunity for External Review

A covered person is entitled to an **external review by an independent review organization ("IRO")** in the following instances:

- the ABD involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency)

- the ABD indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following:
    - standard health care services have not been effective in improving the condition of the covered person
    - standard health care services are not medically appropriate for the covered person
    - no available standard health care service covered by the health plan issuer is more beneficial than the requested health care service

A covered person is entitled to an **external review by the superintendent** in either of the following instances:

- the ABD is based on a contractual issue that does not involve a medical judgment or any medical information
- the ABD indicates that emergency medical services did not meet the prudent layperson definition of emergency and the health plan issuer's decision has already been upheld through an external review by an IRO

Request for External Review

The covered person must request an external review of an ABD within 180 days of the notification date of the internal appeal determination. The request must be in writing except for a request for an expedited external review. Expedited reviews may be requested electronically or orally; however written confirmation of the request must be submitted to the health plan issuer no later than five days after the initial request.

If the request is complete the health plan issuer will initiate the review and notify the covered person in writing. The notice must include:

- confirmation that the request is complete
- the name and contact information for the assigned IRO or the superintendent (whichever is applicable) for the purpose of submitting additional information
- a statement notifying the covered person that they may submit additional information for consideration within 10 business days after receipt of the notice

If the request is not complete the health plan issuer will inform the covered person in writing and specify what information is needed to make the request complete.

If the health plan issuer determines that the ABD is not eligible for external review, the health plan issuer must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the superintendent.

The superintendent may determine the request is eligible for external review regardless of the decision by the health plan issuer and require that the request be referred for external review. The superintendent's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of O.R.C. Chapter 3922.

IRO Assignment

Upon initiation of the external review process by the health plan issuer, the superintendent will assign an IRO and notify the health plan issuer of the name of the assigned IRO through the established web-based system. The assignment will be done on a random basis selecting from those IROs who are qualified to conduct the particular external review based on the nature of the health care service. An IRO who has a conflict of interest described under O.R.C. section 3922.14 may not conduct the external review.

IRO Review and Decision

Except in the case of an expedited review, the IRO must forward, upon receipt, any additional information it receives from the covered person to the health plan issuer. The health plan issuer may reconsider its ABD and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If the health plan issuer reverses the ABD, they must notify the covered person, the assigned IRO and the superintendent within one day of the decision. Upon receipt, the IRO will terminate the review.

In addition to all documents and information considered by the health plan issuer in making the ABD, the IRO must consider all of the following, if available and appropriate:

- the covered person's medical records
- the attending health care professional's recommendation
- consulting reports from appropriate health care professionals and other documents submitted by the health plan issuer, covered person or treating provider
- the terms of coverage under the health benefit plan to ensure the decision is not contrary to the terms of the plan
- the most appropriate practice guidelines, including evidence-based standards and guidelines

- any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization
- the opinion of the IRO's clinical reviewer(s) after considering other sources described here

The IRO is not bound by any decisions or conclusions reached by the health plan issuer during its utilization review process or its internal appeal process. The IRO is not required to, but may accept and consider additional information submitted by the covered person after the end of the 10 business day period.

The assigned IRO must provide a written notice of its decision within 30 days of receipt by the health plan issuer of a request for a standard review or within 72 hours of receipt by the health plan issuer of a request for an expedited review. This notice will be sent to the covered person, the health plan issuer and the superintendent and must include the following information:

- a general description of the reason for the request for the review
- the date the IRO was assigned
- the dates over which the review was conducted
- the date the IRO decision was made
- the rationale for the IRO's decision
- references to the evidence or documentation that was used to reach the decision

If the IRO overturns the health plan issuer's decision, upon receipt of the notice, the health plan issuer will immediately provide coverage for the health care service.

Binding Nature of External Review Decision

An external review decision is binding on the health plan issuer except to the extent the health plan issuer has other remedies available under state law or the superintendent determines that a second external review is required.

An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law unless the superintendent determines that a second external review is required.

A covered person may not file a subsequent request for an external review involving the same ABD that was previously reviewed unless new medical or scientific evidence is submitted to the health plan issuer.

Standard Review

In addition to the provisions and conditions noted throughout this document, the following apply only to standard external review.

Within 5 days after receipt of a complete request for external review, the health plan issuer must provide the assigned IRO with all documents and information that were considered in making the ABD. However, the external review may not be delayed due to the failure of the health plan issuer to submit the required information to the IRO.

An IRO may reverse the ABD if the required information is not provided within 5 days or the IRO may give the health plan issuer more time if requested. If the ABD is reversed due to the lack of required information, the IRO must notify the covered person, the health plan issuer and the superintendent within 1 business day of the decision.

Expedited Review

In addition to the provisions and conditions noted throughout this document, the following apply only to expedited external review.

A covered person may request an expedited external review for an ABD if any of the following applies:

- The covered person's treating physician certifies that the ABD 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 or a standard external review.
- The final ABD 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
- An expedited internal appeal is in process for an ABD of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated

Immediately upon receipt of a request for an expedited external review, the health plan issuer will determine if the request is complete and immediately notify the covered person of its decision. If the request is complete, the health plan issuer will immediately initiate the review and transmit all necessary documents and information considered in making the ABD to the assigned IRO electronically, by facsimile or other expeditious method.

The IRO must make its determination to uphold or reverse the ABD as expeditiously as the covered person's medical condition requires but no more than 72 hours after receipt by the health plan issuer of the request for expedited external review.

The external review may not be delayed due to the failure of the health plan issuer to submit the required information. The IRO may choose to reverse the ABD in that instance.

The IRO must notify the covered person, health plan issuer and the superintendent of any decision promptly. If the notice is not in writing, written confirmation of the decision must be provided within 48 hours of the decision. Expedited external reviews may not be provided for a retrospective final ABD.

Review Related to Experimental or Investigational Treatment

In addition to the provisions and conditions noted throughout this document, the following apply only to external review of an ADB for experimental or investigational treatment.

Upon receipt of a request for a review related to experimental or investigational treatment, the assigned IRO will do both of the following:

- select at least one clinical reviewer, in accordance with O.R.C. section 3922.10 (F) and (G), to conduct the external review
- make the decision to uphold or reverse the ABD based upon the opinion(s) of the clinical reviewer(s)

Each clinical reviewer will conduct the review in accordance with O.R.C. section 3922.10 (H) and must provide a written opinion to the IRO. If a majority of the clinical reviewers recommend the requested health care service be covered, the IRO shall make the decision to reverse the health plan issuer's ABD. If a majority of clinical reviewers recommend the requested health care service should NOT be covered, the IRO shall make the decision to uphold the health plan issuer's ABD.

If the clinical reviewers are evenly split, the IRO must obtain an opinion from an additional clinical reviewer to determine the majority opinion. The additional reviewer must use the same information provided to the other reviewers. The use of an additional reviewer does not extend the time the IRO has to make a decision.

The IRO must provide a written notice as specified in the IRO Review and Decision section of this document. This notice must also include the following:

- the written opinion of each clinical reviewer including the recommendation and rationale for the recommendation
- the principal reason or reasons for the IRO's decision

Review by the Superintendent

A covered person who wishes to request an external review by the superintendent must contact the health plan issuer to request the review. The health plan issuer will submit the request for an external review by the superintendent through the established web-based system.

Upon receipt of the request for an external review, the superintendent will consider whether the health care service is covered under the terms of the contract. The health plan issuer and covered person must provide any information relevant to the review that is required by the superintendent. If the superintendent is not able to determine if the health care service is covered because the determination requires a medical judgment, the superintendent will notify the health plan issuer to initiate an external review by an IRO. If the superintendent determines that the health care service is a covered service the health plan issuer must provide coverage for the service. If the superintendent determines that that health care service is not a covered service the health plan issuer is not required to provide coverage for the service or afford the covered person an external review by an IRO.

Notice Requirements

Please be sure to review the requirements detailed in O.R.C. section 3922.17 for IROs and in O.R.C. section 3922.19 for health plan issuers.