Department of Insurance

Mike DeWine, *Governor*
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Application for Accreditation as an Independent Review Organization (IRO)

Product Regulation (LH) Division, 50 W Town Street, 3rd Floor - Suite 300, Columbus OH 43215
1-614-644-2644 | insurance.ohio.gov

Application for accreditation as an Independent Review Organization (IRO) in Compliance with Ohio Specific Requirements

Submitted in .pdf format by email to: External.Review@insurance.ohio.gov along with proof of current accreditation by a national organization that accredits independent review organizations for external review. Proof shall include a certificate or letter of accreditation. For questions, call 1-614-644-0188

General Information

Legal Name of Applicant			Federal Tax Identification Number	
Type of Entity: ☐ Corporation ☐ Partner ☐ Association ☐ Limited Liability Company ☐ Other				
Contact Person Name	Phone Number	Title		
Business Address Street (do not use P.O. Box)		City	State	Zip
Mailing Address Street (if different from business address)		City	State	Zip
Phone Number	Fax Number	Email Address	State of Incorporation	

List all other states in which Applicant is approved to conduct independent reviews.

_____

Identify all accreditations held by the Applicant.

_____

Has the Applicant ever been refused approval or accreditation to perform independent reviews? ☐ Yes ☐ No
If yes, please explain.

_____

Has the Applicant ever lost approval or accreditation to perform independent reviews? ☐ Yes ☐ No
If yes, please explain.

_____

Organizational Documents and Relationships

1. Attach a chart showing the internal structure of the Applicant's management and administrative staff.
2. Attach a list and brief description of all contractual arrangements between the Applicant, its parent, or any affiliates or subsidiaries.
3. Attach a list and brief description of all contractual arrangements that relate to the Applicant's operations as an independent review organization.
4. Attach an organizational chart of the holding company system that includes all of the information listed below for each entity that controls [as defined in Ohio Revised Code Section 3901.32(B)] or is controlled by the Applicant and all affiliates:
    a. The full legal name of the corporation or organization;
    b. Its state of incorporation or organization;
    c. A description of the goods and services it produces or provides; and
    d. The nature and extent of the affiliation or control.
    e. Note: The holding company system includes any and all affiliates of the Applicant.
5. Include a list of any currently outstanding loans between the Applicant and any affiliates.

Corporations and Limited Liability Companies Only

1. Attach a copy, certified by the Secretary of State, of the Applicant's Articles of Incorporation or Articles of Organization and all amendments to the documents.
2. Attach a copy, certified by a company officer, of the Applicant's bylaws and all amendments.
3. Attach a certificate of good standing from your state of incorporation (corporations only).
4. Is the Applicant a publicly held entity? ☐ Yes ☐ No
5. Are there any stockholders or owners of more than 5% of any stock or options? ☐ Yes ☐ No

   If yes, provide the name, address, percent of ownership, and Federal Tax Identification Number of each stockholder or owner of more than 5% of any stock or options.

Partnership Only

1. Is the Applicant a general or limited partnership?
2. Attached a complete list of all partners, including full name, address, percent or ownership and Federal Tax Identification Number.
3. Attach a true and complete copy of your organizational documents including whatever is required by the state of domicile, the organization's partnership agreement, and all amendments to the documents.

Association and "Other"

Attach a certified copy of organizational documents appropriate to the Applicant. The organizational documents must include: any documents the state of domicile requires to be filed before the entity is authorized to operate in said state; the organization's bylaws; and all amendments to the documents.

Holders of Bonds or Notes

Attach a listing giving the amount of bond or note for any holder of bonds or notes of the Applicant that exceed $100,000 including the name and address for each entity or individual.

Biographical Information

Include the name and a completed Biographical Questionnaire (ODI form INS5037) for:

a. Each Director or Trustee and Officer of the Applicant; and

b. Each similar person of any entity that owns or controls more than 5% of the Applicant.

Agent for Service of Process

Is the Applicant an entity which is domiciled in the state of Ohio? ☐ Yes ☐ No

If yes, provide a certified copy of the Agent for Service of Process form as filed with the Ohio Secretary of State's Office.

If no, the Applicant must apply with the Ohio Secretary of State's Office to conduct business in Ohio as a foreign entity. Please provide a certified copy of the Applicant's license to do business in Ohio and a copy of the Applicant's appointment of an Agent for Service of Process

Anticipated Revenues

Provide below or attach a statement of the percentage of the Applicant's revenues which are anticipated to be to be derived from reviews conducted as an independent review organization and illustrate the method used to determine this amount.

Overview of Ohio Requirements for External Review

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 30 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 72 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 (including an "Authorized Representative" as defined in ORC 3922.01(C));
    b. The health plan issuer; and
    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; and
    f. References to the evidence or documentation, including any evidence-based standards used that were considered in reaching its decision.
4. 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.
5. The health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination within five days after the receipt of a request for an external review that is complete and valid.
6. The covered person, within ten business days after the date of receipt of notice that the external review request is complete, may submit, in writing, additional information for the independent review organization to consider.
7. The independent review organization shall consider the information received from the covered person within the required ten business days when conducting its review.
8. The independent review organization shall review all of the documents and information received from the health plan issuer that it used in making the adverse benefit determination.
9. Except when an expedited request is made, an independent review organization shall forward, upon receipt, a copy of any information received from a covered person during the ten business day period as well as any other information received from the covered person to the health plan issuer.
10. To the extent such documents are available and appropriate, the independent review organization shall consider all of the following when conducting its review:
    a. The covered person's medical records;
    b. The attending health care professional's recommendation;
    c. Consulting reports from appropriate health care professionals and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;
    d. The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of the plan;
    e. The most appropriate practice guidelines, including evidence-based standards, and practice guidelines developed by the federal government, and national or professional medical societies, boards, and associations;
    f. Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering the other sources described above.

11. The organization is not required to, but may, accept and consider additional written information submitted after the end of the ten business day period.

12. Reconsideration of an adverse benefit determination by a health plan issuer based upon receipt of the additional information submitted by the covered period.

13. Upon receipt of notification by a health plan issuer that it has reversed its adverse benefit determination, the assigned independent review organization shall terminate the associated external review.

14. An independent review organization may reverse an adverse benefit determination if the information required is not provided in the allotted time. The independent review organization may grant a request from the health plan issuer for more time to provide the required information.

15. If an adverse benefit determination is reversed based on the failure to provide timely information, the independent review organization shall notify the covered person, the health plan issuer, and the superintendent of insurance, within one business day of making the decision.

16. In selecting clinical reviewers, the assigned independent review organization shall select physicians or other health care professionals who meet the following minimum qualifications:

    a. The clinical reviewer has the same license as the health care provider of the services in question and is a physician or other appropriate health care provider;

    b. Is an expert in the treatment of the medical condition that is subject of the external review;

    c. Is knowledgeable about the requested health care services through clinical experience, within the last three years, treating patients with the same, or a similar medical condition, and, in the case of an external

    d. Holds a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

    e. Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a question as to the clinical reviewer's physical, mental, or professional competence or moral character.

Requirements for expedited reviews, which do not involve an experimental or investigational treatment.

1. The health plan issuer shall immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization electronically, or by facsimile, or other available expeditious method.

2. As expeditiously as the covered person's medical condition requires, but no more than 72 hours after receipt by a health plan issuer of a request for an expedited external review, the assigned independent review organization shall uphold or reverse the adverse benefit determination.

3. An independent review organization shall promptly notify the covered person, health plan issuer, and superintendent of insurance of any decision made. If such notice is not made in writing, the independent review organization shall provide, within 48 hours of making the decision, written confirmation, including the information required under ORC 3922.05(H)(3), of its decision to the covered person, the health plan issuer, and the superintendent of insurance.

4. An expedited external review may not be provided for retrospective final adverse benefit determination.

Requirements for external reviews that involve an experimental or investigational treatment.

1. An independent review organization assigned by the superintendent of insurance shall do both of the following:

    a. Select at least one clinical reviewer to conduct the external review; and

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

2. 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 the 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; and

d. A description and analysis of any evidence based standard considered.

3. 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.

4. 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.

5. In reaching such opinions, a clinical reviewer is not bound by any conclusions reached by the health plan issuer during a utilization review process of its internal appeals process.

6. Each clinical reviewer shall review all of the documents and information received from the health plan issuer that it used in making the adverse benefit determination as well as any other information submitted in writing by the covered person within ten business days from the date the covered person received notice that their request for external review was completed.

7. Within one business day after the receipt of any such information submitted by the covered person, the independent review organization shall forward the information to the health plan issuer. The health plan issuer may reconsider its adverse benefit determination as described in ORC section 3922.06.

8. Each clinical reviewer shall consider the following:

   a. The covered person's medical records;

   b. The attending health care professional's recommendation;

   c. Consulting reports from appropriate health care professional and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;

9. 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.

10. If a majority of the clinical reviewers recommend that the 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.

11. 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 the majority of the clinical reviewers.

12. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.

13. The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision.

Certification

I, acting on behalf of Applicant, certify that Applicant has received accreditation by _____ to conduct independent external reviews. I also state that I have read and understand the requirements for conducting external reviews for Ohio residents and will comply with any related sections of the Ohio Revised Code, the Ohio Administrative Code and all associated rules, policies or procedures of the Superintendent. I understand that these requirements may differ from those of the body that provided the accreditation for external reviews. I also certify that Applicant will adhere to these Ohio requirements when they differ from those of the accrediting body. However, in cases related to timing of reviews, Applicant may comply with the requirements of the accrediting body when those time periods are more stringent than the requirements in Ohio.

I further certify that all of the following is true:

- All reviewers currently hold unrestricted licenses and are in good standing.
- No clinical reviewers have ever been disciplined or sanctioned by a hospital or government entity based upon the quality of care provided.
- For physicians, all clinical reviewers are certified by a nationally recognized medical specialty board in the area that is the subject of their respective reviews.
- All reviewers performing reviews on behalf of Ohio covered persons can complete the review process within the period prescribed by Ohio law.
- The Applicant is not operated by a national, state or local trade association of health benefit plans or health care providers.
- The Applicant agrees not to accept any particular case in the event of conflict of interest. The Applicant as an independent review organization will comply with the conflict of interest requirements of Ohio Revised Code section 3922.14.
- No health plan issuer, or covered person, shall choose or control the choice of clinical reviewers.
- The Applicant will comply with its credentialing process.
- The Applicant will comply with its procedures and Ohio law on confidentiality of medical records and patient identification.
- The Applicant agrees to use only the services of clinical reviewers knowledgeable about the service recommended or requested and with clinical experience within the past three years treating patients with the same or a similar medical condition.

I avow that I have fully and truthfully completed this form to the best of my knowledge, information and belief. I further avow that I have the authority and capacity to execute this certification on behalf of the Applicant. I acknowledge that any fees associated with any external reviews pursuant to the Ohio Revised Code are the sole responsibility of the health plan issuer whose medical decision is being reviewed, and I have no recourse against the Department of Insurance or the State of Ohio to the extent that any health plan issuer fails to pay any medical reviewer fees. I acknowledge that the Superintendent of Insurance has the sole discretion to add or remove the name of any independent review organization from the list of accredited independent review organizations, and the Superintendent's decision to not accredit any organization or to remove any organization's accreditation is not subject to administrative appeal or judicial review under Ohio Revised Code Chapter 119. I hereby waive any and all rights to contest the Superintendent's decision to add, not add, remove or not remove any organization from the list.

I, acting on behalf of _____ (Applicant), being duly sworn, state that I have read and understand the foregoing application and attachments and that the answers are true and correct and further that I am familiar with the insurance laws of the state of Ohio and the rules of the Ohio Department of Insurance.

_____
Applicant

_____
Signature

_____
Print or Type Full Legal Name

_____
Title

State of _____

County of _____

Before me, _____, a notary public in and for the State of _____

on this day personally appeared _____, known to me and acknowledged to me that (s)he executed the same for the purpose and consideration therein expressed, n the capacity therein stated.

Given under this hand and seal of office this _____ day of _____, 20 _____

Affix Notary Seal Here

Notary Public, State of _____