John R. Kasich, *Governor* **Jillian Froment,** *Director*

BULLETIN 2018-04

POLICIES AND PROCEDURES FOR EXTERNAL CONTRACTUAL REVIEW PURSUANT TO OHIO REVISED CODE CHAPTER 3922

Effective June 7, 2018

This bulletin is issued pursuant to Ohio Revised Code (R.C.) Chapter 3922 to clarify the policies and procedures governing the Superintendent's external contractual review of a health plan issuer's adverse benefit determination.

Upon a complete and eligible request by a covered person, a health plan issuer is required to initiate an external review pursuant to R.C. Chapter 3922, applicable federal law and this bulletin.

This bulletin addresses frequent issues the Department encounters related to the submission and processing of external contractual reviews, including issues regarding incomplete submissions, timeliness, and the binding nature of determinations. In order to provide clarity with respect to these and other requirements, the Department may update this bulletin as necessary as other issues are identified.

In addition to reviewing the information provided in this bulletin, health plan issuers should review R.C. Chapter 3922 in its entirety along with any other applicable federal and state laws in order to ensure compliance.

REQUIRED STANDARD INFORMATION: A health plan issuer must provide all of the following documents and records to the Superintendent with a covered person's request for an external contractual review:

- An explanation of the covered person's plan type including: an explanation of the funding type or status as a non-federal governmental plan; whether or not the plan was sold on the Exchange; whether the plan is grandfathered, non-grandfathered or transitional; the provider network type; and whether the plan is individual, small or large group;

- An explanatory summary of the claims and appeals which must include a detailed chronology of the claim(s); applicable contract language; a specific explanation of how the contract language and/or any applicable laws support the issuer's decision; the SERFF tracking number, and, where appropriate, calculations used to determine payment, including, for example, cost sharing or the "greatest of the three" amounts for emergency services.

- The claims submitted by the provider in relation to the adverse benefit determination being reviewed;

- All explanations of benefits related to the claims that are the subject of the adverse benefit determination being reviewed;

- All correspondence, including emails, related to the claims that are the subject of the adverse benefit determination being reviewed;

- All telephone records, including transcripts, recordings or tracking notes in existence that are related to the claims that are the subject of the adverse benefit determination being reviewed; and

- The complete health benefit policy related to the claims that are the subject of the adverse benefit determination being reviewed.

REQUIREMENT FOR TIMELY SUBMISSION OF INFORMATION: Within five calendar days of receiving a request for external contractual review, the health plan issuer must forward to the Superintendent the request and the required standard information specified above. If the Superintendent requests additional specific information, the health plan issuer must submit the information to the Superintendent within the time specified by the Superintendent, or not later than ten calendar days of receiving the information request. A health plan issuer's request for an extension to the deadline to supply information must be submitted in writing prior to the applicable deadline. The Superintendent has discretion to accept information from a covered person at any time during the pendency of the external review.

The Superintendent will not allow a health plan issuer's incomplete provision or late submission of information to impact the duty to provide a prompt external review. If a health plan issuer fails to provide information timely, the Superintendent will consider only that information supplied prior to the expiration of the applicable deadline.

RECONSIDERATION, REVERSAL BY THE HEALTH PLAN ISSUER: A health plan issuer may reconsider its adverse benefit determination at any time. Reconsideration does not suspend or terminate the Superintendent's external contractual review.

If a health plan issuer reverses its determination, it must provide written notice of its reversal within one business day of its decision to the covered person and the Superintendent. Once revised explanations of benefits are issued, the health plan issuer must promptly forward copies to the Superintendent. Upon receipt of the revised explanations of benefits evidencing that the claims at issue have been appropriately covered, the Superintendent will terminate the external contractual review. A pattern or practice of reversals may indicate the need for further review by the Department.

REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION: The Superintendent may find that an adverse benefit determination submitted by the health plan issuer for an external contractual review requires instead, or in addition to the contractual review, a review by an independent review organization. This will depend on whether the health plan issuer's determination was based on contractual health plan provisions, medical judgement, or both.

BINDING DETERMINATION: If the Superintendent overturns the adverse benefit determination, the health plan issuer must, as soon as reasonably practicable, but not more than fifteen calendar days from the date the issuer is notified of the determination, cover the service according to the terms of the plan or avail themselves of any additional remedies that may apply. An external review decision is binding on the health plan issuer and covered person, except to the extent there are other remedies available under applicable state law, or unless the Superintendent determines that, due to the facts and circumstances of an external review, a second external review is required.

Administrative error during the health plan issuer's internal appeal process, including misapplication of the terms of the covered person's health plan, failure to submit timely all relevant information, or failure to correctly apply medical necessity criteria, are not circumstances that the Superintendent would consider as warranting a second external review.

Superintendent of Insurance

Jillian Froment
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