John R. Kasich, Governor

Jillian Froment, Director

The Annual Health Claims External Review Report For the Year 2016

Since 1999, Ohio law provides consumers with the opportunity to request an independent external review for denial, reduction, or termination by their health plan of certain health care services. In 2011, the Ohio Legislature updated the law on external review, incorporating required federal changes and enhancing features of the previous state external review process. The new requirements, codified in Ohio Revised Code (ORC) §3922, became effective for all external review requests submitted on or after January 1, 2012. A summary of the changes and enhancements is provided as ***Attachment 1, Substitute H.B. 218 ExternalReview Revision Highlights*.**

ORC §3922 requires "health plan issuers" (Health Plans), to provide the opportunity for either an external clinical peer review by an accredited Independent Review Organization (IRO) or a contractual review by the Ohio Department of Insurance (ODI) whenever the Health Plan makes an "adverse benefit determination:"

- To deny, reduce, or terminate a health care service or payment;
- Not to issue individual health insurance coverage; or
- To rescind health plan coverage.

The law also directs the Department of Insurance to compile and annually publish information regarding independent external review outcomes. This is the 16th annual report, summarizing the data the Ohio Department of Insurance has collected regarding external reviews conducted from January 1, 2016 through December 31, 2016.

Executive Summary of Independent External Review Outcomes

Medical Peer Reviews by Independent Review Organizations (IRO)

A health plan member or their authorized representative ("covered person"), or a health care provider on behalf of the covered person, may request IRO review of an adverse benefit determination made through a Health Plan's internal appeal process, if the determination involved a medical judgment or was based on any medical information.

During 2016, 451 cases, involving over $5.4 million in health care benefits and services, were submitted for IRO review to determine the appropriateness of a Health Plan's adverse benefit determination. The Health Plan's determination was reversed by the IRO in thirty-nine percent of these cases, saving Ohio health insurance consumers approximately $1,744,000 or about 32% of the cost of all health care benefits and services reviewed.

Over half (51%) of the IRO reviews completed in 2016 were for health care services related to 5 medical specialties (gastroenterology, cardiovascular disease, oncology, surgery, and emergency medicine).

IRO reversals for drug therapy and durable medical equipment totaled approximately $893,000. Reversals for drug therapy totaled over $497,000, while reversals for durable medical equipment totaled almost$396,000. Together, these health care service categories accounted for approximately 51% of the benefit amounts that were reversed in IRO decisions.

Contractual Reviews by the Ohio Department of Insurance (ODI)

When a Health Plan's internal appeal process results in an adverse benefit determination that is based on a contractual issue (not involving medical judgment or medical information), an external request may be submitted by the Health Plan for contractual review by ODI.

During 2016, 123 cases were submitted to ODI for contractual review and ODI completed review of 116 cases. Twenty of the 116 cases reviewed by ODI resulted in reversal of previously denied benefits, recovering over $73,500 in additional benefits for Ohio consumers.

Total Benefits to Consumers since Enactment

Since the 1999 enactment of Ohio's external review law, 6,414 cases have been reviewed by ODI and/or IROs, recovering over $20.4 million in previously denied health care benefits and services for Ohio consumers.

Overview of Ohio External Review Law

ORC §3922 provides that the law applies to "health benefit plans" provided by "health plan issuers," which is defined as including the following entities:

- Traditional Health Insurers;
- Preferred Provider Organizations;
- Health Insuring Corporations (HMOs);
- Fraternal Benefit Societies;
- Self-funded Multiple Employer Welfare Arrangements (MEWAs);
- Nonfederal Government Health Plans; and
- Third Party Administrators (TPAs) administering health benefit plans.

The law requires Health Plans to create an internal appeals process providing covered persons with the opportunity to challenge the denial of health care services or eligibility for coverage. In addition, health care services or coverage denied through a Health Plan's internal appeals process that meet statutorily specified criteria, qualify for external review. Upon request by a covered person, or a health care provider on behalf of a covered person, an external review is required to be completed at no additional cost to the covered person.

A standard external review is required to be completed within thirty (30) days. An expedited review is required to be completed within no more than seventy-two (72) hours for conditions that the covered person's physician certifies could:

- seriously jeopardize the life or health of the covered person;
- jeopardize the covered person's ability to regain maximum function; or
- be significantly less effective if not initiated promptly (for experimental or investigational treatment).

The law provides that clinical peer review by an IRO that has been accredited by ODI must be conducted for any external review request of an adverse benefit determination that is based on medical judgment or involves consideration of medical information. Adverse benefit determinations that do not involve medical judgment or consideration of medical information require contractual review by ODI. Contractual reviews could include adverse benefit determinations based on whether a health care service is a covered service under a Health Plan contract, application of cost sharing or network limitations, or coverage eligibility determinations.

Subject to the other terms, limitations, and conditions of the health plan contract, upon receipt of a notice by an IRO or by ODI to reverse the adverse benefit determination, a Health Plan is required to provide coverage for the health care service(s) in question.

ORC 3922.17(C) directs ODI to compile information about external review outcomes and to publish and provide a report of that information annually to:

- The Governor;
- The speaker and minority leader of the Ohio House of Representatives
- The president and minority leader of the Ohio Senate; and
- The chairs and ranking minority members of the House and Senate committees with jurisdiction over health and insurance issues.

Discussion of Review Outcomes

External Reviews by Independent Review Organizations (IRO)

An analysis of the data over the 12-month period from January 1, 2016 to December 31, 2016, shows that IRO reviews involved benefit determinations amounting to over $5.4 million. IRO decisions reversing adverse benefit determinations saved covered persons approximately $1,744,175. The total benefits recovered for the top 5 cases where Health Plan determinations were reversed was approximately $540,000.

Based on the amount of benefits paid, the top 5 cases reversed through the IRO external review process during this reporting period were:

HEALTH CARE SERVICE	EST. BENEFIT $'s PAID (Reversed)
Drug	**$180,168**
Surgery	**$105,972**
Durable Medical Equipment	**$97,650**
Drug	**$86,247**
Drug	**$70,000**

Number of IRO Reviews Conducted / Outcomes

For the reporting period of January 1, 2016 to December 31, 2016, 451 external review requests were assigned to IROs for review.

Standard reviews, permitting a 30-day maximum review period, were requested in 403 of the cases. The IROs reversed adverse benefit determinations in 146 standard reviews (36%) and affirmed the Health Plan's determination in the remaining 257 standard reviews (64%).

Forty-eight IRO cases were expedited, requiring a 72-hour maximum review period. In 31 of those cases (65%), the IROs reversed the Health Plan's original determination.

Average Time Required to Conduct IRO Reviews

The average time to process a standard IRO review was 18 days. The average time to process an expedited IRO review was 58 hours. Ninety-seven percent of all IRO reviews were completed without complication and within appropriate timeframes.

Cost of IRO External Reviews

The cost of an external review by an IRO is based on several factors, including, whether the review type is standard or expedited, the Health Plan basis for the adverse benefit determination, and the medical condition involved. For example, a review to determine medical necessity only requires one reviewer, while review of experimental or investigational services may require a panel of reviewers. IRO review cost is paid by the Health Plan. In 2016, the total cost to Ohio Health Plans for IRO reviews was approximately $363,260. The average cost per standard review was about $798; while the average cost per expedited review was approximately $866. Expedited review costs accounted for $41,558 (11%) of total review costs.

Summary of Services and Procedures

In 2016, IRO external reviews spanned a wide variety of health service categories. The highest proportion of reviews were for testing (36%) and durable medical equipment (15%) followed by reviews for surgery (14%) and drug therapy (12%). These four service categories accounted for approximately 77% of the reviews conducted and $1,279,624 or about 73%, of the approximately $1,744,175 in benefit determinations reversed by IRO decisions. Together, review of emergency transport and hospitalization comprised another 15% of the reviews conducted and a corresponding 13% of the benefit determination amounts reversed. These 6 service categories represent approximately 92% of the 451 cases reviewed and over 86% of the total adverse benefit determination amounts that were reversed in 2016. ***See Attachment 2, IRO Reviews By Services and Procedures.***

Medical Specialty Types

During the process to initiate an IRO review, a Health Plan identifies the medical specialty category required for the review. Case review activity by category of medical specialty is listed in ***Attachment 3, IRO Reviews by Medical Specialty***.

Based on the number of reviews, the five medical specialties most often required for IRO review during this reporting period were:

MEDICAL SPECIALTY	NUMBER OF REVIEWS	TOTAL BENEFIT $'s REVIEWED	TOTAL BENEFIT $'s PAID (Reversed)
Gastroenterology	**59**	**$258,160**	**$54,738**
Cardiovascular Disease	**53**	**$394,544**	**$226,344**
Oncology (Non-Pediatric)	**45**	**$339,997**	**$163,984**
Surgery	**41**	**$758,091**	**$105,265**
Emergency Medicine	**34**	**$921,403**	**$117,950**

External Contractual Reviews by ODI

The law requires ODI to review contractual adverse benefit determinations that do not involve medical judgment or consideration of medical information. Examples include determination that a health care service is not a covered benefit under the contract, eligibility for coverage (including determinations not to issue or to rescind coverage), and application of contractual cost sharing or network limitations. If ODI finds that a contractual external review request involves medical judgment or consideration of medical information, ODI immediately directs the Health Plan to submit the request for review by an IRO.

ODI has established an internal contractual review team comprised of specialists from the Office of Legal Services, the Office of Product Regulation, and the Consumers Services Division. There is no charge to Health Plans for contractual external reviews.

Number of Contractual Reviews Conducted / Outcomes

From January 1, 2016 to December 31, 2016, 116 contractual external reviews were completed by ODI. As a result, Ohio consumers received $73,594 of previously denied health benefits.

Health Plan contractual adverse benefit determinations were upheld in 96 cases (83%) and reversed in 20 cases (17%).

Contractual Reasons for Review

The breakdown by category for contractual reviews performed by ODI during this reporting period is as follows:

REVIEW CATEGORY	TOTAL NUMBER OF REVIEWS	TOTAL BENEFIT $'s PAID (Reversed)
Service Not Covered-Non-medical Judgment	89	$56,765
Denial to Issue Coverage	11	$2,257
Eligibility for Coverage	9	N/A
Emergency Services/Prudent Layperson Standard	7	$14,572

Average Time Required to Conduct Contractual Reviews

The time required to conduct a comprehensive contractual review is dependent on the complexity of the case and the need for legal review of a consumer's contract. The average time for ODI completion of a contractual review in 2016 was 67 days.

Conclusion

Since enactment of Ohio law in 1999, providing consumers with the opportunity for independent external appeal of adverse health insurance determinations, ODI has maintained a significant investment of staff resources and technology to ensure thorough and timely resolution of external review appeals. As a result, 6,414 external reviews have been conducted, recovering over $20.4 million in previously denied health care benefits for Ohio consumers.

The ODI website offers secure, easy access to both the IRO and the contractual external review processes. A secure web-accessible application is the portal used by Health Plans and IROs to facilitate the IRO review process and to provide outcome reporting to ODI. This technology is also utilized by ODI to closely monitor IRO review activity.

ODI's ongoing efforts to publicize the opportunity and the process for external review include providing information in consumer guides and on the department website (www.insurance.ohio.gov). Consumers can also contact ODI for information or assistance with the external review process by completing an online consumer complaint form on the department website.

ODI and the Ohio State Medical Association (OSMA) collaborated to develop and distribute an external review "toolkit" of informative materials targeted specifically to Ohio consumers and health care providers. An online version of this toolkit is available on the department's website at http://www.insurance.ohio.gov/Consumer/Pages/HealthCoverageAppealToolkit.aspx.

ODI is committed to ensuring that the protections and benefits provided under Ohio external appeal laws are increasingly made known and remain highly accessible to all eligible Ohio consumers.

For more information, please contact the following individuals:

Consumer Inquiries:

- Jana Jarrett, Assistant Director, Consumer Services, (614) 644-3378

Legislative Inquiries:

- Meredith Alexander, Assistant Director, Government Relations, (614) 728-0070

Media Inquiries:

- Chris Brock, Assistant Director, Communications, (614) 728-1539

Attachments

- **Attachment 1 - Substitute HB218 Revision Highlights**
- **Attachment 2 – IRO Reviews By Type Of Services**
- **Attachment 3 – IRO Reviews By Medical Specialty**
- **Attachment 4 – 10 Year Comparison of IRO Cases By Report Year**
- **Attachment 5 – Five Year Health Carrier Summary**
- **Attachment 6 – Total Number of IRO Cases By Report Year**
- **Attachment 7 – Health Carrier Summary**