External Review Procedures Summary

Understanding the External Review Process

All health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. An adverse benefit determination is a decision by the health plan issuer not to provide benefits because they believe services are not covered, excluded, or limited under the plan, or they believe the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, and level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking 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

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information

- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least 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

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination 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 treatment is delayed until after the time frame of an expedited internal appeal

- The covered person's treating physician certifies that the final adverse benefit determination 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 treatment is delayed until after the time frame of a standard external review

- The final adverse benefit determination 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

- 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

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person)

<u>External Review by the Ohio Department of Insurance</u> - A covered person is entitled to an external review by the Department in either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or any medical information

- The adverse benefit determination indicates that emergency medical services did not meet the 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

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through the health plan issuer within 180 days of the date of the notice of final adverse benefit determination issued by their health plan issuer.

All requests must be in writing and can be sent by U.S. Mail, email or fax. Additionally, expedited external reviews may be requested orally by telephone. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the health plan issuer will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The health plan issuer will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

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 adverse benefit determination 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 Ohio Department of Insurance.

The Ohio Department of Insurance 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 Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When a health plan issuer initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with the health plan issuer, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by the health plan issuer in making the adverse benefit determination, any information submitted by the covered person and other information such as: the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will 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 Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the independent review organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also include the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

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. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law

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

If You Have Questions About Your Rights or Need Assistance

You may contact your health plan issuer or:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx