(123rd General Assembly)
(Amended Substitute House Bill Number 4)

AN ACT

To amend sections 1751.11, 1751.19, 1751.33, 1751.35, 1751.77, 1751.78, 1751.81, 1751.82, 1753.24, and 5747.01; to amend, for the purpose of adopting new section numbers as indicated in parentheses, sections 1751.83 (1751.821), 1751.84 (1751.822), 1751.85 (1751.823), and 1753.24 (1751.85); and to enact new sections 1751.83 and 1751.84 and sections 1751.811, 1751.831, 1751.87, 1751.88, 1751.89, 1753.13, 3901.80, 3901.81, 3901.82, 3901.83, 3901.84, 3923.65, 3923.66, 3923.67, 3923.68, 3923.681, 3923.69, 3923.70, 3923.75, 3923.76, 3923.77, 3923.78, and 3923.79 of the Revised Code to establish procedures for enrollee appeals of health care coverage decisions by health insuring corporations, sickness and accident insurers, and state employee benefit plans and to make other changes in the laws related to health insuring corporations, sickness and accident insurers, and state employee benefit plans.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1751.11, 1751.19, 1751.33, 1751.35, 1751.77, 1751.78, 1751.81, 1751.82, 1753.24, and 5747.01 be amended, sections 1751.83 (1751.821), 1751.84 (1751.822), 1751.85 (1751.823), and 1753.24 (1751.85) be amended for the purpose of adopting new section numbers as indicated in parentheses, and new sections 1751.83 and 1751.84 and sections 1751.811, 1751.831, 1751.87, 1751.88, 1751.89, 1753.13, 3901.80, 3901.81, 3901.82, 3901.83, 3901.84, 3923.65, 3923.66, 3923.67, 3923.68, 3923.681, 3923.69, 3923.70, 3923.75, 3923.76, 3923.77, 3923.78, and 3923.79 of the Revised Code be enacted to read as follows:

Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which

ealth care benefits are provided.

(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one toll-free telephone number that provides the subscriber with access ~~to health care~~, to information on a twenty-four-hours-per-day, seven-days-per-week basis, as to how health care services may be obtained. The identification card or document shall also list at least one toll-free number that, during normal business hours, provides the subscriber with access to information on the coverage available under the subscriber's health care plan and information on the health care plan's internal and external review processes.

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(D) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used:

(1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive;

(2) Unless it contains a clear, concise, and complete statement of the following:

(a) The health care services and insurance or other benefits, if any, to which ~~the~~ an enrollee is entitled under the health care plan;

(b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments;

(c) ~~The~~ An enrollee's personal financial obligation for noncovered services;

(d) Where and in what manner general information and information as to how health care services may be obtained is available, including ~~the~~ a toll-free telephone number;

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment provisions with respect to all contracts. The statement of the premium rate, however, may be contained in a separate insert.

(f) The method utilized by the health insuring corporation for resolving enrollee complaints;

(g) The utilization review, internal review, and external review procedures established under sections 1751.77 to 1751.85 of the Revised Code.

(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the group policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following:

(a) The enrollee's discharge from the hospital;

(b) The determination by the enrollee's attending physician that inpatient care is no longer medically indicated for the enrollee; however, nothing in division (D)(3)(b) of this section precludes a health insuring corporation from engaging in utilization review as described in the evidence of coverage.

(c) The enrollee's reaching the limit for contractual benefits;

(d) The effective date of any new coverage.

(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any guaranty fund, and that in the event of the health insuring corporation's insolvency, ~~the~~ an enrollee is protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered;

(5) Unless it contains a provision that states, in substance, that in the event of the insolvency of the health insuring corporation, ~~the~~ an enrollee

may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to the health insuring corporation, whether or not the health insuring corporation authorized the use of the provider or health care facility.

(E) Notwithstanding divisions (C) and (D) of this section, a health insuring corporation may use an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare contract, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or an evidence of coverage that provides for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or an evidence of coverage that provides for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The evidence of coverage has been approved by the United States department of health and human services, the United States office of personnel management, the Ohio department of human services, or the department of administrative services.

(2) The evidence of coverage is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the Ohio department of human services, or the department of administrative services.

Sec. 1751.19. (A) A health insuring corporation shall establish and maintain a complaint system that has been approved by the superintendent of insurance to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by subscribers or enrollees concerning any matter relating to services provided, directly or indirectly, by the health insuring corporation, including, but not limited to, ~~claims~~ complaints regarding ~~the scope of coverage for health care services, and denials,~~ cancellations~~,~~ or nonrenewals of coverage. Complaints regarding a health insuring corporation's decision to deny, reduce, or terminate coverage for health care services are subject to section 1751.83 of

the Revised Code.

(B) A health insuring corporation shall provide a timely written response to each written complaint it receives. ~~Responses to written complaints relating to quality or appropriateness of care shall set forth a statement informing the complainant in detail of any rights the complainant may have to submit such complaint to any professional peer review organization or health insuring corporation peer review committee that has been set up to monitor the quality or appropriateness of provider services rendered. Such statement shall set forth the name of the peer review organization or health insuring corporation peer review committee, its address, telephone number, and any other pertinent data that will enable the complainant to seek further independent review of the complaint. Such appeal shall not be made to the peer review corporation or health insuring corporation peer review committee until the complaint system of the health insuring corporation has been exhausted.~~

(C) Copies of complaints and responses, including medical records related to those complaints, shall be available to the superintendent and the director of health for inspection for three years. Any document or information provided to the superintendent pursuant to this division that contains a medical record is confidential, and is not a public record subject to section 149.43 of the Revised Code.

(D) A health insuring corporation shall establish and maintain a procedure to accept complaints over the telephone or in person. These complaints are not subject to the reporting requirement under division (C) of section 1751.32 of the Revised Code.

(E) A health insuring corporation may comply with this section and section 1751.83 of the Revised Code by establishing one system for receiving and reviewing complaints and requests for internal review from enrollees and subscribers if the system meets the requirements of both sections.

Sec. 1751.33. (A) Each health insuring corporation shall provide to its subscribers, by mail, a description of the health insuring corporation, its method of operation, its service area, its most recent provider list, ~~and~~ its complaint procedure established pursuant to section 1751.19 of the Revised Code, and a description of its utilization review, internal review, and external review processes established under sections 1751.77 to 1751.85 of the Revised Code. At the request of or with the approval of the subscriber, a health insuring corporation may provide this information by electronic means rather than by mail. A health insuring corporation providing basic health care services or supplemental health care services shall provide this

information annually. A health insuring corporation providing only specialty health care services shall provide this information biennially.

(B) Each health insuring corporation, upon the request of a subscriber, shall make available its most recent statutory financial statement.

Sec. 1751.35. (A) The superintendent of insurance may suspend or revoke any certificate of authority issued to a health insuring corporation under this chapter if the superintendent finds that:

(1) The health insuring corporation is operating in contravention of its articles of incorporation, its health care plan or plans, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 1751.03 of the Revised Code, unless amendments to such submissions have been filed and have taken effect in compliance with this chapter.

(2) The health insuring corporation fails to issue evidences of coverage in compliance with the requirements of section 1751.11 of the Revised Code.

(3) The contractual periodic prepayments or premium rates used do not comply with the requirements of section 1751.12 of the Revised Code.

(4) The health insuring corporation enters into a contract, agreement, or other arrangement with any health care facility or provider, that does not comply with the requirements of section 1751.13 of the Revised Code, or the corporation fails to provide an annual certificate as required by section 1751.13 of the Revised Code.

(5) The director of health has certified, after a hearing conducted in accordance with Chapter 119. of the Revised Code, that the health insuring corporation no longer meets the requirements of section 1751.04 of the Revised Code.

(6) The health insuring corporation is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(7) The health insuring corporation has failed to implement the complaint system that complies with the requirements of section 1751.19 of the Revised Code.

(8) The health insuring corporation, or any agent or representative of the corporation, has advertised, merchandised, or solicited on its behalf in contravention of the requirements of section 1751.31 of the Revised Code.

(9) The health insuring corporation has unlawfully discriminated against any enrollee or prospective enrollee with respect to enrollment, disenrollment, or price or quality of health care services.

(10) The continued operation of the health insuring corporation would

be hazardous or otherwise detrimental to its enrollees.

(11) The health insuring corporation has submitted false information in any filing or submission required under this chapter or any rule adopted under this chapter.

(12) The health insuring corporation has otherwise failed to substantially comply with this chapter or any rule adopted under this chapter.

(13) The health insuring corporation is not operating a health care plan.

(14) The health insuring corporation has failed to comply with any of the requirements of sections 1751.77 to 1751.88 of the Revised Code.

(B) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Chapter 119. of the Revised Code.

(C) When the certificate of authority of a health insuring corporation is suspended, the health insuring corporation, during the period of suspension, shall not enroll any additional subscribers or enrollees except newborn children or other newly acquired dependents of existing subscribers or enrollees, and shall not engage in any advertising or solicitation whatsoever.

(D) When the certificate of authority of a health insuring corporation is revoked, the health insuring corporation, following the effective date of the order of revocation, shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the health insuring corporation. The health insuring corporation shall engage in no further advertising or solicitation whatsoever. The superintendent, by written order, may permit such further operation of the health insuring corporation as the superintendent may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Sec. 1751.77. As used in sections 1751.77 to ~~1751.86~~ 1751.88 of the Revised Code, unless otherwise specifically provided:

(A) "Adverse determination" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service ~~covered under a policy, contract, or agreement of the health insuring corporation~~ has been reviewed and, based upon the information provided, the health care service does not meet the ~~health insuring corporation's~~ requirements for benefit payment under the health insuring corporation's policy, contract, or agreement, and coverage is therefore denied, reduced, or terminated.

(B) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(C) "Authorized person" means a parent, guardian, or other person

authorized to act on behalf of an enrollee with respect to health care decisions.

(D) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other specified health conditions.

~~(D)~~(E) "Certification" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service ~~covered under a policy, contract, or agreement of the health insuring corporation~~ has been reviewed and, based upon the information provided, the health care service satisfies the ~~health insuring corporation's~~ requirements for benefit payment under the health insuring corporation's policy, contract, or agreement.

~~(E)~~(F) "Clinical peer" means a physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a provider who is not a physician, "clinical peer" means either a physician or a provider holding the same license as the provider who provided the health care services.

~~(F)~~(G) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insuring corporation to determine the necessity and appropriateness of health care services.

~~(G)~~(H) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

~~(H)~~(I) "Discharge planning" means the formal process for determining, prior to a patient's discharge from a health care facility, the coordination and management of the care that the patient is to receive following discharge from a health care facility.

~~(I)~~(J) "Participating provider" means a provider or health care facility that, under a contract with a health insuring corporation or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insuring corporation.

~~(J)~~(K) "Physician" means a provider ~~authorized~~ who holds a certificate issued under ~~chapter~~ Chapter 4731. of the Revised Code ~~to~~ authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

~~(K)~~(L) "Prospective review" means utilization review that is conducted

prior to an admission or a course of treatment.

~~(L)~~(M) "Retrospective review" means utilization review of medical necessity that is conducted after health care services have been provided to a patient. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

~~(M)~~(N) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for proposed health care services to assess the clinical necessity and appropriateness of the proposed health care services.

~~(N)~~(O) "Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

~~(O)~~(P) "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans.

Sec. 1751.78. (A)(1) Sections 1751.77 to ~~1751.86~~ 1751.88 of the Revised Code apply to any health insuring corporation that provides or performs utilization review services in connection with its policies, contracts, and agreements ~~providing~~ covering basic health care services and to any designee of the health insuring corporation, or to any utilization review organization that performs utilization review functions on behalf of the health insuring corporation in connection with policies, contracts, or agreements of the health insuring corporation ~~providing~~ covering basic health care services.

(2) Nothing in sections 1751.77 to 1751.82 or section ~~1751.85~~ 1751.823 of the Revised Code shall be construed to require a health insuring corporation to provide or perform utilization review services in connection with health care services provided under a policy, plan, or agreement of supplemental health care services or specialty health care services.

(B)(1) Each health insuring corporation shall be responsible for monitoring all utilization review and internal review activities carried out by, or on behalf of, the health insuring corporation and for ensuring that all requirements of sections 1751.77 to ~~1751.86~~ 1751.88 of the Revised Code, and any rules adopted thereunder, are met. The health insuring corporation shall also ensure that appropriate personnel have operational responsibility for the conduct of the health insuring corporation's utilization review

program.

(2) If a health insuring corporation contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 1751.77 to ~~1751.86~~ 1751.88 of the Revised Code, and any rules adopted thereunder, the superintendent of insurance shall hold the health insuring corporation responsible for monitoring the activities of the utilization review organization or other entity and for ensuring that the requirements of those sections and rules are met.

Sec. 1751.81. (A) As used in this section~~:~~

~~(1) "Enrollee" includes the representative of an enrollee.~~

~~(2) "Necessary~~, "Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(B) A health insuring corporation shall maintain written procedures for determining whether a requested service is a service covered under the terms of an enrollee's policy, contract, or agreement, making utilization review determinations, and ~~for~~ notifying enrollees, ~~and~~ participating providers, and health care facilities acting on behalf of enrollees, of its determinations.

(C) For ~~initial~~ prospective review determinations, a health insuring corporation shall make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination.

(1) In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information.

(1) In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification.

(2) In the case of an adverse determination, the health insuring

corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee shall be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.

(E) For retrospective review determinations, a health insuring corporation shall make the determination within thirty business days after receiving all necessary information.

(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.

(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

(F)(1) The time frames set forth in divisions (C), (D), and (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

(2) An enrollee, an authorized person, the enrollee's provider, or the health care facility rendering health care service to an enrollee may proceed with a request for an internal review pursuant to section 1751.83 of the Revised Code if a health insuring corporation fails to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section. The ENROLLEE MAY REQUEST A REVIEW WITHOUT THE APPROVAL OF THE PROVIDER OR THE HEALTH CARE FACILITY RENDERING THE HEALTH CARE SERVICE. THE PROVIDER OR HEALTH CARE FACILITY MAY NOT REQUEST A REVIEW WITHOUT THE PRIOR CONSENT OF THE ENROLLEE.

The health insuring corporation's failure to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section shall be deemed to be an adverse determination by the health insuring corporation for the purpose of initiating an internal review.

(G) A written notification of an adverse determination shall include the

principal reason or reasons for the determination, instructions for initiating ~~an appeal or~~ a reconsideration of the determination under section 1751.82 of the Revised Code or an internal review under section 1751.83 of the Revised Code, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation shall provide the clinical rationale for an adverse determination in writing to any party who received notice of the adverse determination and who follows the instructions for a request.

(H)(1) A health insuring corporation shall have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review.

(2) A health insuring corporation shall not use unreasonable requests for information to delay making a determination.

(3) If the health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification. An enrollee need not be granted an internal review pursuant to section 1751.83 of the Revised Code based on a health insuring corporation's failure to make a timely determination, if the health insuring corporation's delay in making a determination and notification is caused by the failure of a health care facility, provider, or enrollee to release all necessary information, in which case the health insuring corporation shall notify the enrollee in writing of the reason for the delay.

Sec. 1751.811. In lieu of conducting a prospective, concurrent, or retrospective review under section 1751.81 of the Revised Code, providing a reconsideration under section 1751.82 of the Revised Code, or conducting an internal review under section 1751.83 of the Revised Code, a health insuring corporation may afford an enrollee an opportunity for an external review under section 1751.84 or 1751.85 of the Revised Code. If an external review is conducted pursuant to this section, the health insuring corporation is not required to afford the enrollee an opportunity for any of the reviews that were disregarded pursuant to this section, including the external review that may have resulted from a review that was disregarded pursuant to this section, unless new clinical information is submitted to the health insuring corporation.

Sec. 1751.82. (A) In a case involving ~~an initial~~ a prospective determination or a concurrent review determination, a health insuring corporation shall give the provider or health care facility rendering the health care service an opportunity to request in writing on behalf of the enrollee a reconsideration of an adverse determination by the reviewer making the adverse determination. The provider or health care facility may

not request a reconsideration without the prior consent of the enrollee. The reconsideration shall occur within three business days after the health insuring corporation's receipt of the written request for reconsideration, and shall be conducted between the provider or health care facility rendering the health care service and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.

(B) If the reconsideration process described in division (A) of this section does not resolve the difference of opinion, ~~the adverse determination may be appealed by~~ the enrollee, an authorized person, or the provider or health care facility acting on behalf of the enrollee may request an internal review under section 1751.83 of the Revised Code. The provider or health care facility may not request an internal review without the prior consent of the enrollee.

(C) Reconsideration is not a prerequisite to ~~a standard~~ an internal or ~~expedited appeal~~ external review of an adverse determination.

(D) The time period allowed by division (A) of this section for a reconsideration of an adverse determination shall not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation shall maintain written procedures for making such an expedited reconsideration.

Sec. ~~1751.83~~ 1751.821. A health insuring corporation may present evidence of compliance with the requirements of sections 1751.77 to 1751.82 of the Revised Code by submitting evidence to the superintendent of insurance of its accreditation by an independent, private accrediting organization, such as the national committee on quality assurance, the national quality health council, the joint commission on accreditation of health care organizations, or the American accreditation healthcare commission/utilization review accreditation commission. The superintendent, upon review of the organization's accreditation process, may determine that such accreditation constitutes compliance by the health insuring corporation with the requirements of these sections.

Sec. ~~1751.84~~ 1751.822. Each participating provider or health care facility submitting a claim shall cooperate with the utilization review program of a health insuring corporation or utilization review organization and shall provide the health insuring corporation or its designee access to an enrollee's medical records during regular business hours, or copies of those records at a reasonable cost.

Sec. ~~1751.85~~ 1751.823. A health insuring corporation shall annually file a certificate with the superintendent of insurance certifying its compliance

with sections 1751.77 to 1751.82 of the Revised Code.

Sec. 1751.83. A health insuring corporation shall establish and maintain an internal review system that has been approved by the superintendent of insurance. The system shall provide for review by a clinical peer and include adequate and reasonable procedures for review and resolution of appeals from enrollees concerning adverse determinations made under section 1751.81 of the Revised Code, including procedures for verifying and reviewing appeals from enrollees whose medical conditions require expedited review.

A health insuring corporation shall consider and provide a written response to each request for an internal review NOT LATER THAN SIXTY DAYS AFTER RECEIPT OF THE REQUEST, EXCEPT THAT IF THE SERIOUSNESS OF THE ENROLLEE'S MEDICAL CONDITION REQUIRES AN EXPEDITED REVIEW, THE HEALTH INSURING CORPORATION SHALL PROVIDE THE WRITTEN RESPONSE NOT LATER THAN SEVEN DAYS AFTER RECEIPT OF THE REQUEST. The response shall state the reason for the health insuring corporation's decision, inform the enrollee of the right to pursue a further review, and explain the procedures for initiating the review, including the time frames within which the enrollee must request the review, as specified in section 1751.84 or 1751.85 of the Revised Code. Failure by a health insuring corporation to provide a written response within the time frames specified under this section shall be deemed a denial by the health insuring corporation for purposes of requesting a review under section 1751.831, 1751.84, or 1751.85 of the Revised Code.

If the health insuring corporation has denied, reduced, or terminated coverage for a health care service on the grounds that the service is not a service covered under the terms of the enrollee's policy, contract, or agreement, the response shall inform the enrollee of the right to request a review by the superintendent of insurance under section 1751.831 of the Revised Code. If the health insuring corporation has denied, reduced, or terminated coverage for a health care service on the grounds that the service is not medically necessary, the response shall inform the enrollee of the right to request an external review under section 1751.84 of the Revised Code, except that if the enrollee meets the criteria set forth in division (A) of section 1751.85 of the Revised Code, the response shall inform the enrollee of the right to request an external review under section 1751.85 of the Revised Code.

The health insuring corporation shall make available to the superintendent for inspection copies of all documents in the health insuring

corporation's possession related to reviews conducted pursuant to this section, including medical records related to those reviews, and of responses, for three years following completion of the review.

Sec. 1751.831. THE SUPERINTENDENT OF INSURANCE SHALL ESTABLISH AND MAINTAIN A SYSTEM FOR RECEIVING AND REVIEWING REQUESTS FOR REVIEW FROM OR ON BEHALF OF ENROLLEES WHO, UNDER SECTION 1751.83 of the Revised Code, HAVE BEEN DENIED COVERAGE OF A HEALTH CARE SERVICE OR HAD COVERAGE REDUCED OR TERMINATED when the grounds for the denial, reduction, or termination is that THE SERVICE IS NOT A SERVICE COVERED UNDER THE TERMS OF THE ENROLLEE'S POLICY, CONTRACT, OR AGREEMENT.

On receipt of a written request from an enrollee or authorized person, the superintendent shall consider whether the health care service is a service covered under the terms of the enrollee's policy, contract, or agreement, except that the superintendent shall not conduct a review under this section unless the enrollee has exhausted the health insuring corporation's internal review process established pursuant to section 1751.83 of the Revised Code. The health insuring corporation and the enrollee or authorized person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

Unless the superintendent is not able to do so because making the determination requires resolution of a medical issue, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the enrollee's contract, policy, or agreement. The superintendent shall notify the enrollee and the health insuring corporation of the superintendent's determination or that the superintendent is not able to make a determination.

If the superintendent notifies the health insuring corporation that making the determination requires the resolution of a medical issue, the health insuring corporation shall afford the enrollee an opportunity for external review under section 1751.84 or 1751.85 of the Revised Code. If the superintendent notifies the health insuring corporation that the health service is a covered service, the health insuring corporation shall either cover the service or afford the enrollee an opportunity for an external review under section 1751.84 or 1751.85 of the Revised Code. if the superintendent notifies the health insuring corporation that the health care service is not a covered service, the health insuring corporation is not required to cover the service or afford the enrollee an external review.

Sec. 1751.84. (A) EXCEPT AS PROVIDED IN DIVISIONs (B) and

(C) OF THIS SECTION, A HEALTH INSURING CORPORATION SHALL afford AN ENROLLEE AN opportunity for an EXTERNAL REVIEW if both of the following are the case:

(1) The HEALTH INSURING CORPORATION HAS DENIED, reduced, or terminated COVERAGE FOR WHAT WOULD BE A COVERED HEALTH CARE SERVICE EXCEPT FOR THE FACT THAT THE HEALTH INSURING CORPORATION HAS DETERMINED THAT THE HEALTH CARE SERVICE IS NOT MEDICALLY NECESSARY;

(2) Except in the case of an expedited review, the service, plus any ancillary services and follow-up care, will cost the enrollee more than five hundred dollars if the proposed service is not covered by the health insuring corporation.

EXTERNAL REVIEW SHALL BE conducted IN ACCORDANCE WITH THIS SECTION, EXCEPT THAT IF AN ENROLLEE WITH A TERMINAL CONDITION MEETS ALL OF THE CRITERIA OF DIVISION (A) OF SECTION 1751.85 OF THE REVISED CODE, AN EXTERNAL REVIEW SHALL BE CONDUCTED UNDER THAT SECTION.

(B) AN ENROLLEE need NOT BE AFFORDED A REVIEW UNDER THIS SECTION IN any OF THE FOLLOWING CIRCUMSTANCES:

(1) The superintendent of insurance has DETERMINED UNDER SECTION 1751.831 OF THE REVISED CODE THAT THE HEALTH CARE SERVICE IS NOT a service COVERED UNDER THE TERMS OF THE ENROLLEE'S POLICY, CONTRACT, OR AGREEMENT.

(2) Except as provided in section 1751.811 of the Revised Code, THE ENROLLEE HAS FAILED TO EXHAUST THE HEALTH INSURING CORPORATION'S INTERNAL review PROCESS ESTABLISHED pursuant to SECTION 1751.83 OF THE REVISED CODE.

(3) The enrollee has previously been afforded an external review for the same adverse determination and no new clinical information has been submitted to the health insuring corporation.

(C)(1) A health insuring corporation may deny a request for an EXTERNAL REVIEW OF AN ADVERSE DETERMINATION if it is REQUESTED LATER THAN sixty DAYS AFTER THE enrollee's receipt of NOTICE of the result of an INTERNAL review brought UNDER SECTION 1751.83 OF THE REVISED CODE. An external REVIEW MAY BE REQUESTED BY THE ENROLLEE, an authorized person, THE ENROLLEE'S PROVIDER, OR A HEALTH CARE FACILITY RENDERING HEALTH CARE SERVICE TO THE ENROLLEE. THE ENROLLEE MAY REQUEST A REVIEW WITHOUT THE APPROVAL

OF THE PROVIDER OR THE HEALTH CARE FACILITY RENDERING THE HEALTH CARE SERVICE. THE PROVIDER OR HEALTH CARE FACILITY MAY NOT REQUEST A REVIEW WITHOUT THE prior CONSENT OF THE ENROLLEE.

(2) AN EXTERNAL REVIEW MUST BE REQUESTED IN WRITING, EXCEPT THAT IF THE ENROLLEE HAS A CONDITION THAT REQUIRES EXPEDITED REVIEW, THE REVIEW MAY BE REQUESTED ORALLY OR BY ELECTRONIC MEANS. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the health insuring corporation not later than five days after the oral or written request is submitted.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification from the enrollee's provider or the health care facility rendering the health care service to the enrollee that the proposed service, plus any ancillary services and follow-up care, will cost the enrollee more than five hundred dollars if the proposed service is not covered by the health insuring corporation.

(3) FOR AN EXPEDITED REVIEW, THE ENROLLEE'S PROVIDER MUST CERTIFY THAT THE ENROLLEE'S CONDITION COULD, in the absence of immediate medical attention, RESULT IN ANY OF THE FOLLOWING:

(a) PLACING THE HEALTH OF THE ENROLLEE OR, WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF the ENROLLEE or the UNBORN CHILD, IN SERIOUS JEOPARDY;

(b) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS;

(c) SERIOUS DYSFUNCTION of ANY BODILY ORGAN OR PART.

(D) THE PROCEDURES USED IN CONDUCTING AN EXTERNAL REVIEW OF AN ADVERSE DETERMINATION SHALL INCLUDE ALL OF THE FOLLOWING:

(1) THE REVIEW SHALL BE CONDUCTED BY an INDEPENDENT review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code.

(2) EXCEPT AS PROVIDED IN DIVISION (D)(3) AND (4) OF THIS SECTION, NEITHER THE CLINICAL PEER NOR ANY HEALTH CARE FACILITY WITH WHICH THE CLINICAL PEER IS AFFILIATED SHALL HAVE ANY PROFESSIONAL, FAMILIAL, OR FINANCIAL AFFILIATION WITH ANY OF THE FOLLOWING:

(a) THE HEALTH INSURING CORPORATION OR ANY OFFICER, DIRECTOR, OR MANAGERIAL EMPLOYEE OF THE HEALTH INSURING CORPORATION;

(b) THE ENROLLEE, THE ENROLLEE'S PROVIDER, OR THE PRACTICE GROUP OF THE ENROLLEE'S PROVIDER;

(c) THE HEALTH CARE FACILITY AT WHICH THE HEALTH CARE SERVICE REQUESTED BY THE ENROLLEE WOULD BE PROVIDED;

(d) THE DEVELOPMENT OR MANUFACTURE OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR THERAPY PROPOSED FOR THE ENROLLEE.

(3) DIVISION (D)(2) OF THIS SECTION DOES NOT PROHIBIT A CLINICAL PEER FROM CONDUCTING A REVIEW UNDER any of THE FOLLOWING CIRCUMSTANCES:

(a) THE CLINICAL PEER IS AFFILIATED WITH AN ACADEMIC MEDICAL CENTER THAT PROVIDES HEALTH CARE SERVICES TO ENROLLEES OF THE HEALTH INSURING CORPORATION.

(b) THE CLINICAL PEER HAS STAFF PRIVILEGES AT A HEALTH CARE FACILITY THAT PROVIDES HEALTH CARE SERVICES TO ENROLLEES OF THE HEALTH INSURING CORPORATION.

(c) THE CLINICAL PEER IS A PARTICIPATING PROVIDER BUT WAS NOT INVOLVED WITH THE HEALTH INSURING CORPORATION'S ADVERSE DETERMINATION.

(4) DIVISION (D)(2) OF THIS SECTION DOES NOT PROHIBIT THE HEALTH INSURING CORPORATION FROM PAYING THE INDEPENDENT REVIEW ORGANIZATION FOR THE CONDUCT OF THE REVIEW.

(5) AN ENROLLEE SHALL NOT BE REQUIRED TO PAY FOR ANY PART OF THE COST OF THE REVIEW. THE COST OF THE REVIEW SHALL BE BORNE BY THE HEALTH INSURING CORPORATION.

(6)(a) THE HEALTH INSURING CORPORATION SHALL PROVIDE TO THE INDEPENDENT REVIEW ORGANIZATION CONDUCTING THE REVIEW A COPY OF THOSE RECORDS IN its POSSESSION THAT ARE RELEVANT TO THE ENROLLEE'S MEDICAL CONDITION AND THE REVIEW. THE RECORDS SHALL BE USED SOLELY FOR THE PURPOSE OF THIS DIVISION.

AT THE REQUEST OF THE INDEPENDENT REVIEW ORGANIZATION, THE HEALTH INSURING CORPORATION, ENROLLEE, OR THE PROVIDER OR HEALTH CARE FACILITY RENDERING HEALTH CARE SERVICES TO THE ENROLLEE SHALL PROVIDE ANY ADDITIONAL INFORMATION THE INDEPENDENT

review organization requests TO COMPLETE the REVIEW. A request for additional information may be made in writing, orally, or by electronic means. the independent review organization shall submit the request to the enrollee and health insuring corporation. If a request is submitted orally or by electronic means to an enrollee or health insuring corporation, not later than five days after the request is submitted, the independent review organization shall provide written confirmation of the request. If the review was initiated by a provider or health care facility, a copy of the request shall be submitted to the provider or health care facility.

(b) AN INDEPENDENT review organization IS NOT REQUIRED TO MAKE A DECISION IF IT HAS NOT RECEIVED ANY REQUESTED INFORMATION THAT IT CONSIDERS NECESSARY TO COMPLETE A REVIEW. An independent review organization that does not make a decision for this reason shall notify the enrollee and the health insuring corporation that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An Oral or electronic notice shall be confirmed in writing not later than five days after the oral or electronic notice is made. If the review was initiated by a provider or health care facility, a copy of the notice shall be submitted to the provider or health care facility.

(7) THE HEALTH INSURING CORPORATION MAY ELECT TO COVER THE SERVICE REQUESTED AND TERMINATE THE REVIEW. THE HEALTH INSURING CORPORATION SHALL NOTIFY the enrollee and ALL other PARTIES INVOLVED WITH THE DECISION BY mail or, with the consent or approval of the enrollee, by electronic means.

(8) IN MAKING ITS DECISION, AN INDEPENDENT review organization CONDUCTING THE REVIEW SHALL TAKE INTO ACCOUNT all of THE FOLLOWING:

(a) INFORMATION SUBMITTED BY THE HEALTH INSURING CORPORATION, THE ENROLLEE, THE ENROLLEE'S PROVIDER, and THE HEALTH CARE FACILITY RENDERING THE HEALTH CARE SERVICE, INCLUDING THE FOLLOWING:

(i) THE ENROLLEE'S MEDICAL RECORDS;

(ii) THE STANDARDS, CRITERIA, AND CLINICAL RATIONALE USED BY THE HEALTH INSURING CORPORATION TO MAKE ITS DECISION.

(b) FINDINGS, STUDIES, RESEARCH, AND OTHER RELEVANT DOCUMENTS OF GOVERNMENT AGENCIES AND NATIONALLY RECOGNIZED ORGANIZATIONS, INCLUDING THE NATIONAL

NSTITUTES OF HEALTH OR ANY BOARD RECOGNIZED BY THE NATIONAL INSTITUTES OF HEALTH, THE NATIONAL CANCER INSTITUTE, THE NATIONAL ACADEMY OF SCIENCES, THE UNITED STATES FOOD AND DRUG ADMINISTRATION, THE HEALTH CARE FINANCING ADMINISTRATION OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH;

(c) RELEVANT FINDINGS IN PEER-REVIEWED MEDICAL OR SCIENTIFIC LITERATURE, PUBLISHED OPINIONS OF NATIONALLY RECOGNIZED MEDICAL experts, and clinical guidelines adopted by relevant national MEDICAL SOCIETIES.

(9)(a) IN THE CASE OF AN EXPEDITED REVIEW, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN SEVEN DAYS AFTER the FILING of THE REQUEST FOR REVIEW. IN ALL OTHER CASES, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN THIRTY DAYS AFTER THE FILING OF THE REQUEST. THE INDEPENDENT review organization SHALL SEND A COPY OF ITS DECISION TO THE HEALTH INSURING CORPORATION AND THE ENROLLEE. IF THE ENROLLEE'S PROVIDER OR THE HEALTH CARE FACILITY RENDERING HEALTH CARE SERVICES TO THE ENROLLEE REQUESTED THE review, THE INDEPENDENT review organization SHALL also SEND A COPY OF ITS DECISION TO THE ENROLLEE'S PROVIDER OR THE HEALTH CARE fACILITY.

(b) THE INDEPENDENT review organization's decision SHALL INCLUDE A DESCRIPTION OF THE ENROLLEE'S CONDITION AND THE PRINCIPAL REASONS FOR THE DECISION AND AN EXPLANATION OF THE CLINICAL RATIONALE FOR THE DECISION.

(E) The independent review organization shall base its decision on the information submitted under division (D)(8) of this section. In making its decision, the independent review organization shall consider safety, efficacy, appropriateness, and cost effectiveness.

(F) THE HEALTH INSURING CORPORATION SHALL PROVIDE ANY COVERAGE determined BY THE INDEPENDENT review organization's DECISION to be medically necessary, subject to the other terms, limitations, and conditions of the enrollee's contract. The decision shall apply only to the individual enrollee's external review.

Sec. ~~1753.24~~ 1751.85. (A) Each health insuring corporation shall

establish a reasonable external, independent review process to examine the health insuring corporation's coverage decisions for enrollees who meet all of the following criteria:

(1) The enrollee has a terminal condition that, according to the current diagnosis of the enrollee's physician, has a high probability of causing death within two years.

(2) THE ENROLLEE REQUESTS A REVIEW NOT LATER THAN SIXTY DAYS AFTER RECEIPT BY THE ENROLLEE OF NOTICE OF THE RESULT OF AN INTERNAL REVIEW UNDER SECTION 1751.83 OF THE REVISED CODE.

(3) The enrollee's physician certifies that the enrollee has the condition described in division (A)(1) of this section and any of the following situations are applicable:

(a) Standard therapies have not been effective in improving the condition of the enrollee;

(b) Standard therapies are not medically appropriate for the enrollee;

(c) There is no standard therapy covered by the health insuring corporation that is more beneficial than therapy described in division (A)~~(3)~~(4) of this section.

~~(3)~~(4) The enrollee's physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than standard therapies, or, the enrollee has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

~~(4)~~(5) The enrollee has been denied coverage by the health insuring corporation for a drug, device, procedure, or other therapy recommended or requested pursuant to division (A)~~(3)~~(4) of this section, and has exhausted ~~all~~ the health insuring corporation's internal ~~appeals~~ review process established pursuant to section 1751.83 of the Revised Code.

~~(5)~~(6) The drug, device, procedure, or other therapy, ~~recommended or requested pursuant to division (A)(3) of this section,~~ for which coverage has been denied would be a covered health care service except for the health insuring corporation's determination that the drug, device, procedure, or other therapy is experimental or investigational.

(B) A review shall be requested in writing, except that if the enrollee's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the health insuring

corporation not later than five days after the oral or written request is submitted.

(C) The external, independent review process established by a health insuring corporation shall meet all of the following criteria:

(1) Except as provided in division ~~(C)~~(E) of this section, the process shall ~~offer~~ afford all enrollees who meet the criteria set forth in division (A) of this section the opportunity to have the health insuring corporation's decision to deny coverage of the recommended or requested therapy reviewed under the process. ~~Each eligible enrollee shall be notified of that opportunity within five business days after the health insuring corporation denies coverage.~~

(2) The review ~~of the health insuring corporation's decision~~ shall be conducted by ~~experts selected by~~ an independent ~~entity that has been retained by the health insuring corporation for this purpose. The independent entity shall be either an academic medical center or an entity that has as its primary function, and that receives a majority of its revenue from, the provision of expert reviews and related services~~ review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code.

The independent ~~entity~~ review organization shall select a panel to conduct the review, which panel shall be composed of at least three physicians or other providers who, through clinical experience in the past three years, are experts in the treatment of the enrollee's medical condition and knowledgeable about the recommended or requested therapy. ~~If the independent entity retained by the health insuring corporation is an academic medical center, the panel may include experts affiliated with or employed by the academic medical center.~~

In either of the following circumstances, an exception may be made to the requirement that the review be conducted by an expert panel composed of a minimum of three physicians or other providers:

(a) A review may be conducted by an expert panel composed of only two physicians or other providers if an enrollee has consented in writing to a review by the smaller panel;

(b) A review may be conducted by a single expert physician or other provider if only one expert physician or other provider is available for the review.

(3) Neither the health insuring corporation nor the enrollee shall choose, or control the choice of, the physician or other provider experts.

(4) ~~Neither the~~ The selected experts ~~nor~~, any health care facility with which an expert is affiliated, and the independent ~~entity~~ review organization

arranging for the experts' review, shall not have any professional, familial, or financial affiliation with ~~the~~ any of the following:

(a) The health insuring corporation~~, except that~~ or any officer, director, or managerial employee of the health insuring corporation;

(b) The enrollee, the enrollee's physician, or the practice group of the enrollee's physician;

(c) The health care facility at which the recommended or requested therapy would be provided;

(d) The development or manufacture of the PRINCIPAL drug, device, procedure, or therapy involved in the recommended or requested therapy.

However, experts affiliated with academic medical centers who provide ~~healthcare~~ health care services to enrollees of the health insuring corporation may serve as experts on the review panel. ~~This~~ Further, experts with staff privileges at a health care facility that provides health care services to enrollees of the health insuring corporation, as well as experts who are participating providers, but who were not involved with the health insuring corporation's denial of coverage for the therapy under review, may serve as experts on the review panel. These nonaffiliation ~~provision does~~ provisions do not preclude a health insuring corporation from paying for the experts' review, as specified in division ~~(B)~~(C)(5) of this section. ~~The experts shall have no patient-physician relationship or other affiliation with an enrollee whose request for therapy is under review or with a provider whose recommendation for therapy is under review.~~

(5) Enrollees shall not be required to pay for any part of the ~~external, independent~~ cost of the review. The ~~costs~~ cost of the review shall be borne by the health insuring corporation.

(6) The health insuring corporation shall provide to the independent ~~entity~~ review organization arranging for the experts' review ~~and to the enrollee and the enrollee's physician~~ a copy of those ~~medical~~ records in the health insuring corporation's possession that are relevant to the enrollee's medical condition ~~for which therapy has been recommended or requested~~ and the review. The ~~medical~~ records shall be disclosed solely to the expert reviewers and shall be used solely for the purpose of this section. AT THE REQUEST OF THE EXPERT REVIEWERS, THE HEALTH INSURING CORPORATION OR THE PHYSICIAN RECOMMENDING THE THERAPY SHALL PROVIDE ANY ADDITIONAL INFORMATION THAT THE EXPERT REVIEWERS REQUEST TO COMPLETE THE REVIEW. AN EXPERT REVIEWER IS NOT REQUIRED TO RENDER AN OPINION IF THE REVIEWER HAS NOT RECEIVED ANY REQUESTED INFORMATION THAT THE REVIEWER CONSIDERS

NECESSARY TO COMPLETE THE REVIEW.

(7)(a) The opinions of the experts on the panel shall be rendered within thirty days after the enrollee's request for review. If the enrollee's physician determines that a therapy would be significantly less effective if not promptly initiated, the opinions shall be rendered within seven days after the enrollee's request for review.

(b) In conducting the review, the experts on the panel shall take into account all of the following:

(i) Information submitted by the health insuring corporation, the enrollee, and the enrollee's physician, including the enrollee's medical records and the standards, criteria, and clinical rationale used by the health insuring corporation to reach its coverage decision;

(ii) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations;

(iii) Relevant findings in peer-reviewed medical or scientific literature and published opinions of nationally recognized medical experts;

(iv) Clinical guidelines adopted by relevant national medical societies;

(v) SAFETY, EFFICACY, APPROPRIATENESS, AND COST EFFECTIVENESS.

(8) Each expert on the panel shall provide the independent ~~entity~~ review organization with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely to be more beneficial to the enrollee than standard therapies.

(9) Each expert's opinion shall be presented in written form and shall include the following information:

(a) A description of the enrollee's condition;

(b) A description of the indicators relevant to 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 enrollee than standard therapies;

(c) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;

(d) A description of the enrollee's suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

(10) The independent ~~entity~~ review organization shall provide the health insuring corporation with the opinions of the experts. The health insuring corporation shall make the experts' opinions available to the enrollee and the enrollee's physician, upon request.

(11) The ~~decision~~ opinion of the majority of the experts on the panel, rendered pursuant to division ~~(B)~~(C)(8) of this section, is binding on the health insuring corporation with respect to that enrollee. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, then the health insuring corporation's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the health insuring corporation may, in its discretion, cover the therapy. However, any coverage provided pursuant to division ~~(B)~~(C)(11) of this section is subject to the terms, limitations, and conditions of the enrollee's contract with the health insuring corporation.

(12) The health insuring corporation shall have written policies describing the external, independent review process. ~~The health insuring corporation shall disclose the availability of the external, independent review process in the health insuring corporation's evidence of coverage and disclosure forms.~~

~~(C)~~(D) AT ANY TIME DURING THE EXTERNAL, INDEPENDENT REVIEW PROCESS, THE HEALTH INSURING CORPORATION MAY ELECT TO COVER THE RECOMMENDED OR REQUESTED HEALTH CARE SERVICE AND TERMINATE THE REVIEW. THE HEALTH INSURING CORPORATION SHALL NOTIFY THE ENROLLEE AND ALL OTHER PARTIES INVOLVED BY MAIL OR, WITH THE CONSENT OR APPROVAL OF THE ENROLLEE, BY ELECTRONIC MEANS.

(E) If a health insuring corporation's initial denial of coverage for a therapy recommended or requested pursuant to division (A)~~(3)~~(4) of this section is based upon an external, independent review of that therapy meeting the requirements of division ~~(B)~~(C) of this section, this section shall not be a basis for requiring a second external, independent review of the recommended or requested therapy.

~~(D)~~(F) The health insuring corporation shall annually file a certificate with the superintendent of insurance certifying its compliance with the requirements of this section.

Sec. 1751.87. Nothing in sections 1751.77 to 1751.85 of the Revised Code shall be construed to create a cause of action against any of the following:

(A) An employer that provides health care benefits to employees through a health insuring corporation;

(B) A clinical peer, medical expert, or independent review organization that participates in an external review under section 1751.84 or 1751.85 of the Revised Code;

(C) A health insuring corporation that provides coverage for benefits in accordance with division (F) of section 1751.84 or division (C)(11) of section 1751.85 of the Revised Code.

Sec. 1751.88. CONSISTENT WITH THE RULES OF EVIDENCE, A WRITTEN DECISION OR OPINION PREPARED BY or for AN INDEPENDENT review organization UNDER SECTION 1751.84 OR 1751.85 OF THE REVISED CODE SHALL BE ADMISSIBLE IN ANY CIVIL ACTION RELATED TO THE COVERAGE DECISION THAT WAS THE SUBJECT OF THE decision or OPINION. THE INDEPENDENT review organization's DECISION OR OPINION SHALL BE PRESUMED TO BE A SCIENTIFICALLY VALID AND ACCURATE DESCRIPTION OF THE STATE OF MEDICAL KNOWLEDGE AT THE TIME IT WAS WRITTEN.

CONSISTENT WITH THE RULES OF EVIDENCE, ANY PARTY TO A CIVIL ACTION RELATED TO A HEALTH INSURING CORPORATION'S COVERAGE DECISION INVOLVING AN INVESTIGATIONAL OR EXPERIMENTAL DRUG, DEVICE, OR TREATMENT MAY INTRODUCE INTO EVIDENCE ANY APPLICABLE MEDICARE REIMBURSEMENT STANDARDS ESTABLISHED UNDER TITLE XVIII OF THE "SOCIAL SECURITY ACT," 49 STAT. 620(1935), 42 U.S.C.A301, AS AMENDED.

Sec. 1751.89. Sections 1751.77 to 1751.85 of the Revised Code do not apply to either of the following:

(A) Coverage provided to beneficiaries enrolled in the medicare+choice program operated under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(B) Coverage provided to recipients of assistance under the medicaid program operated pursuant to Chapter 5111. of the Revised Code.

Sec. 1753.13. EVERY INDIVIDUAL OR GROUP HEALTH INSURING CORPORATION POLICY, CONTRACT, OR AGREEMENT THAT PROVIDES BASIC HEALTH CARE SERVICES BUT DOES NOT ALLOW DIRECT ACCESS TO OBSTETRICIANS OR GYNECOLOGISTS SHALL PERMIT A FEMALE ENROLLEE TO OBTAIN covered OBSTETRIC AND GYNECOLOGICAL SERVICES FROM A participating OBSTETRICIAN OR GYNECOLOGIST WITHOUT OBTAINING A REFERRAL FROM THE ENROLLEE'S PRIMARY CARE PROVIDER.

NO INDIVIDUAL OR GROUP HEALTH INSURING CORPORATION POLICY, CONTRACT, OR AGREEMENT MAY LIMIT THE NUMBER OF ALLOWABLE VISITS TO A participating

OBSTETRICIAN OR GYNECOLOGIST. A HEALTH INSURING CORPORATION MAY REQUIRE A PARTICIPATING OBSTETRICIAN OR GYNECOLOGIST TO COMPLY WITH THE HEALTH INSURING CORPORATION'S COVERAGE PROTOCOLS AND PROCEDURES, including utilization review, FOR OBSTETRIC AND GYNECOLOGICAL SERVICES.

A HEALTH INSURING CORPORATION policy, contract, or agreement MAY NOT IMPOSE ADDITIONAL COPAYMENTS FOR DIRECTLY ACCESSED OBSTETRIC AND GYNECOLOGICAL SERVICES, UNLESS the policy, contract, or agreement imposes additional copayments for direct access to any participating provider other than a primary care provider.

Sec. 3901.80. As used in sections 3901.80 to 3901.83 of the Revised Code, "clinical peer" and "physician" have the same meanings as in section 1751.77 of the Revised Code.

(A) THE SUPERINTENDENT of insurance SHALL ACCREDIT INDEPENDENT review organizations for the purposes of external reviews conducted under sections 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, and 3923.77 of the Revised Code. The superintendent may, in accordance with Chapter 119. of the Revised Code and in consultation with the director of health, adopt rules governing the accreditation of independent review organizations. In DEVELOPING THE rules, THE SUPERINTENDENT may TAKE INTO CONSIDERATION THE STANDARDS ESTABLISHED BY NATIONAL ORGANIZATIONS THAT ACCREDIT ORGANIZATIONS providing EXPERT REVIEWS AND RELATED SERVICES. THE SUPERINTENDENT, after reviewing the accreditation process used by a national organization to accredit an independent review organization, may determine that accreditation by the national organization constitutes accreditation by the superintendent. The superintendent shall not accredit any independent review organization that is operated by a national, state, or local trade association of health benefit plans or health care providers.

(B) Each INDEPENDENT review organization SHALL USE THE SERVICES OF clinical peers outside the staff of the independent review organization to conduct external reviews. None of the following shall choose, or control the choice of, the clinical peers:

(1) A health insuring corporation;

(2) An enrollee;

(3) An insurer;

(4) An insured;

(5) A public employee benefit plan;

(6) A plan member.

(C) The superintendent shall maintain a randomly organized roster of independent review organizations accredited under this section for purposes of assigning independent review organizations to conduct external reviews. The superintendent may, in accordance with Chapter 119. of the Revised Code, adopt rules governing the assignment of independent review organizations.

On receipt of a request by a health insuring corporation, insurer, or public employee benefit plan, the superintendent shall randomly assign two independent review organizations that are accredited under division (A) of this section. After receipt of the names of the two independent review organizations, the health insuring corporation, insurer, or public employee benefit plan shall select one of the assigned independent review organizations to conduct the external review.

No health insuring corporation, insurer, or public employee benefit plan shall engage in a pattern of excluding a particular independent review organization based on previous findings on behalf of enrollees, insureds, or plan members. If the superintendent makes such a finding, it is an unfair trade practice.

Sec. 3901.81. An INDEPENDENT review organization selected under section 3901.80 of the Revised Code to conduct an external review under section 1751.84, 3923.67, or 3923.76 of the Revised Code SHALL utilize the services of CLINICAL PEERS WHO HAVE EXPERTISE IN THE TREATMENT OF THE MEDICAL CONDITION of the enrollee, insured, or plan member AND CLINICAL EXPERIENCE in the past three years WITH THE SERVICE requested or RECOMMENDED BY THE ENROLLEE, insured, or plan member OR THE PROVIDER of the enrollee, insured, or plan member. The review shall be conducted by a single clinical peer, unless the health insuring corporation, insurer, or public employee benefit plan determines that more than one clinical peer is needed. THE CLINICAL PEER MUST HOLD A LICENSE THAT IS NOT RESTRICTED IN ANY MANNER BY THE STATE IN WHICH THE CLINICAL PEER IS LICENSED. The clinical peer shall not have been disciplined or sanctioned by a hospital or government entity based on the quality of care provided by the clinical peer. In the CASE OF A PHYSICIAN, THE CLINICAL PEER MUST BE CERTIFIED BY A NATIONALLY RECOGNIZED MEDICAL SPECIALTY BOARD IN THE AREA THAT IS THE SUBJECT OF THE REVIEW.

Sec. 3901.82. (A) Each INDEPENDENT review organization that

conducts EXTERNAL REVIEWS UNDER SECTION 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, or 3923.77 OF THE REVISED CODE SHALL ANNUALLY REPORT THE FOLLOWING INFORMATION TO THE SUPERINTENDENT OF INSURANCE in a format prescribed by the superintendent:

(1) THE NUMBER OF reviews conducted;

(2) THE NUMBER OF reviews DECIDED IN FAVOR OF ENROLLEES, insureds, and plan members AND THE NUMBER DECIDED IN FAVOR OF HEALTH INSURING CORPORATIONs, insurers, and public employee benefit plans;

(3) THE AVERAGE TIME REQUIRED TO conduct a review;

(4) THE NUMBER AND PERCENTAGE OF reviews IN WHICH A DECISION WAS NOT REACHED IN THE TIME REQUIRED UNDER DIVISION (D) OF SECTION 1751.84, DIVISION (C) OF SECTION 1751.85, division (D) of section 3923.67, division (C) of section 3923.68, division (D) of section 3923.76, or division (C) of section 3923.77 OF THE REVISED CODE;

(5) A summary of the diagnoses, drugs, devices, services, procedures, and therapies that have been the subject of external review;

(6) The costs associated with external reviews, including the rates charged by the independent review organization to conduct the reviews;

(7) The medical specialty or type of provider used to conduct each external review, as related to the specific medical condition of the enrollee, insured, or plan member;

(8) ANY ADDITIONAL INFORMATION REQUIRED BY THE SUPERINTENDENT BY RULE ADOPTED PURSUANT TO DIVISION (C) OF THIS SECTION.

(B) The superintendent of insurance shall comply with applicable state and federal laws related to the confidentiality of medical records.

(C) THE SUPERINTENDENT MAY, IN ACCORDANCE WITH CHAPTER 119. OF THE REVISED CODE, ADOPT RULES REQUIRING INDEPENDENT review organizations TO PROVIDE ADDITIONAL INFORMATION ON THE consideration AND DISPOSITION OF EXTERNAL reviews BROUGHT UNDER SECTION 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, or 3923.77 OF THE REVISED CODE.

(D) THE SUPERINTENDENT SHALL COMPILE AND ANNUALLY PUBLISH THE INFORMATION COLLECTED UNDER THIS SECTION AND REPORT THE INFORMATION TO THE GOVERNOR, THE SPEAKER and minority leader OF THE HOUSE OF REPRESENTATIVES, THE PRESIDENT and minority leader OF THE

SENATE, AND THE CHAIRS and ranking minority members OF THE HOUSE AND SENATE COMMITTEES WITH JURISDICTION OVER HEALTH AND INSURANCE ISSUES.

Sec. 3901.83. When a record containing information pertaining to the medical history, diagnosis, prognosis, or medical condition of an enrollee of a health insuring corporation, insured of an insurer, or plan member of a public employee benefit plan is provided to the superintendent of insurance for any reason under sections 1751.77 to 1751.88, 3923.66 to 3923.70, or 3923.75 to 3923.79 of the Revised Code, regardless of the source, The superintendent shall maintain the confidentiality of the record. The record in the superintendent's possession is not a public record under section 149.43 of the Revised Code, except to the extent that information from the record is used in preparing reports under section 3901.82 of the Revised Code.

Sec. 3901.84. An independent review organization and any medical expert or clinical peer the organization uses in conducting an external review under section 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, or 3923.77 of the Revised Code is not liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review.

This section does not grant immunity from civil liability or professional disciplinary action to an independent review organization, medical expert, or clinical peer for an action that is outside the scope of authority granted under section 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, or 3923.77 of the Revised Code.

Sec. 3923.65. (A) AS USED IN THIS SECTION:

(1) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION THAT MANIFESTS ITSELF BY SUCH ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT A PRUDENT LAYPERSON WITH AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN ANY OF THE FOLLOWING:

(a) PLACING THE HEALTH OF THE INDIVIDUAL OR, WITH RESPECT TO A PREGNANT WOMAN, THE HEALTH OF THE WOMAN OR HER UNBORN CHILD, IN SERIOUS JEOPARDY;

(b) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS;

(c) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

(2) "EMERGENCY SERVICES" MEANS THE FOLLOWING:

(a) A MEDICAL SCREENING EXAMINATION, AS REQUIRED BY FEDERAL LAW, THAT IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT, TO EVALUATE AN EMERGENCY MEDICAL CONDITION;

(b) SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT THAT ARE REQUIRED BY FEDERAL LAW TO STABILIZE AN EMERGENCY MEDICAL CONDITION AND ARE WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, INCLUDING ANY TRAUMA AND BURN CENTER OF THE HOSPITAL.

(B) EVERY INDIVIDUAL OR GROUP POLICY OF SICKNESS AND ACCIDENT INSURANCE THAT PROVIDES HOSPITAL, SURGICAL, OR MEDICAL EXPENSE COVERAGE SHALL COVER EMERGENCY SERVICES WITHOUT REGARD TO THE DAY OR TIME THE EMERGENCY SERVICES ARE RENDERED OR TO WHETHER THE POLICYHOLDER, THE HOSPITAL'S EMERGENCY DEPARTMENT WHERE THE SERVICES ARE RENDERED, OR AN EMERGENCY PHYSICIAN TREATING THE POLICYHOLDER, OBTAINED PRIOR AUTHORIZATION FOR THE EMERGENCY SERVICES.

(C) EVERY INDIVIDUAL POLICY OR CERTIFICATE FURNISHED BY AN INSURER IN CONNECTION WITH ANY SICKNESS AND ACCIDENT INSURANCE POLICY SHALL PROVIDE INFORMATION REGARDING THE FOLLOWING:

(1) THE SCOPE OF COVERAGE FOR EMERGENCY SERVICES;

(2) THE APPROPRIATE USE OF EMERGENCY SERVICES, INCLUDING THE USE OF THE 9-1-1 SYSTEM AND ANY OTHER TELEPHONE ACCESS SYSTEMS UTILIZED TO ACCESS PREHOSPITAL EMERGENCY SERVICES;

(3) ANY COPAYMENTS FOR EMERGENCY SERVICES.

(D) THIS SECTION DOES NOT APPLY TO ANY INDIVIDUAL OR GROUP POLICY OF SICKNESS AND ACCIDENT INSURANCE COVERING ONLY ACCIDENT, CREDIT, DENTAL, DISABILITY INCOME, LONG-TERM CARE, HOSPITAL INDEMNITY, MEDICARE SUPPLEMENT, MEDICARE, TRICARE, SPECIFIED DISEASE, OR VISION CARE; COVERAGE UNDER A ONE-TIME LIMITED DURATION POLICY OF NO LONGER THAN SIX MONTHS; COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY

NSURANCE; INSURANCE ARISING OUT OF WORKERS' COMPENSATION OR SIMILAR LAW; AUTOMOBILE MEDICAL PAYMENT INSURANCE; OR INSURANCE UNDER WHICH BENEFITS ARE PAYABLE WITH OR WITHOUT REGARD TO FAULT AND WHICH IS STATUTORILY REQUIRED TO BE CONTAINED IN ANY LIABILITY INSURANCE POLICY OR EQUIVALENT SELF-INSURANCE.

Sec. 3923.66. (A) AS USED IN SECTIONS 3923.66 TO 3923.70 OF THE REVISED CODE:

(1) "CLINICAL PEER" AND "PHYSICIAN" HAVE THE SAME MEANINGS AS IN SECTION 1751.77 OF THE REVISED CODE.

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of an insured with respect to health care decisions.

(B) Sections 3923.66 to 3923.70 of the Revised Code do not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(C) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for review from insureds who have been denied COVERAGE OF a health care service on the grounds that the service is not a service covered under the terms of the insured's policy or certificate.

On receipt of a written request from an insured OR AUTHORIZED PERSON, the superintendent shall consider whether the health care service is a service covered under the terms of the insured's policy or certificate, except that the superintendent shall not conduct a review under this section unless the insured has exhausted the insurer's internal review process. The insurer and the insured OR AUTHORIZED PERSON shall provide the superintendent with any information REQUIRED BY THE SUPERINTENDENT THAT IS IN THEIR POSSESSION AND IS GERMANE TO THE REVIEW.

Unless THE SUPERINTENDENT is not able to do so because making the determination requires resolution of a medical issue, the superintendent shall determine whether the health care service at issue is a service covered

under the terms of the insured's policy or certificate. The superintendent shall notify the insured and the insurer of its determination or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the superintendent notifies the insurer that making the determination requires the resolution of a medical issue, the insurer shall afford the insured an opportunity for external review under section 3923.67 or 3923.68 of the Revised Code. If the superintendent notifies the insurer that the health care service is not a covered service, the insurer is not required to cover the service or afford the insured an external review.

Sec. 3923.67. (A) Except as provided in divisions (B) and (C) of this section, an insurer shall afford an insured an OPPORTUNITY for an external review of a coverage denial when requested by the insured or authorized person, if both of the following are the case:

(1) The insurer has denied, reduced, or terminated coverage for what would be a covered health care service except that the insurer has determined that the health care service is not medically necessary.

(2) except in the case of EXPEDITED review, The proposed service, plus any ancillary services and follow-up care, will cost the insured more than five hundred dollars if the proposed service is not covered by the insurer.

external review shall be conducted in accordance with this section, except that if an insured with a terminal condition meets all of the criteria of division (A) of section 3923.68 of the Revised Code, an external review shall be conducted under that section.

(B) An insured need not be afforded a review under this section in any of the following circumstances:

(1) the superintendent of insurance has determined under section 3923.66 of the Revised Code that the health care service is not a service covered under the terms of the insured's policy or certificate.

(2) the insured has failed to exhaust the insurer's internal review process.

(3) the insured has previously afforded an external review for the same denial of coverage, and no new clinical information has been submitted to the insurer.

(C)(1) An insurer may deny a request for an external review if it is requested later than sixty days after receipt by the insured of NOTICE FROM the superintendent of insurance under section 3923.66 of the Revised Code that making a determination requires the resolution of a medical issue. An external review may be requested by the insured, an authorized person,

the insured's provider, or a health care facility rendering health care service to the insured. The insured may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the insured.

(2) An external review must be requested in writing, except that if the insured has a condition that requires EXPEDITED review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the insurer not later than five days after the request is made.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification from the insured's provider or the health care facility rendering the health care service to the insured that the proposed service, plus any ancillary services and follow-up care, will cost the insured more than five hundred dollars if the proposed service is not covered by the insurer.

(3) For an expedited review, the insured's provider must certify that the insured's condition could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the insured or, with respect to a pregnant woman, the health of the insured or the unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(d) The procedures used in conducting an external review shall include all of the following:

(1) The review shall be conducted by an independent review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code.

(2) eXCEPT AS PROVIDED IN dIVISIONs (d)(3) and (4) of this section, neither the clinical peer nor any health care facility with which the clinical peer is affiliated shall have any professional, familial, or financial affiliation with any of the following:

(a) The insurer or any officer, director, or managerial employee of the insurer;

(b) The insured, the insured's provider, or the practice group of the insured's provider;

(c) The health care facility at which the health care service requested by the insured would be provided;

(d) the development or manufacture of the principal drug, device, procedure, or therapy proposed for the insured.

(3) Division (d)(2) of this section does not prohibit a clinical peer from conducting a review under any of the following circumstances:

(a) The clinical peer is affiliated with an academic medical center that provides health care services to insureds of the insurer.

(b) the clinical peer has staff privileges at a health care facility that provides health care services to insureds of the insurer.

(c) The clinical peer has a contractual relationship with the insurer but was not involved with the insurer's coverage decision.

(4) Division (d)(2) of this section does not prohibit the insurer from paying the independent review organization for the conduct OF the review.

(5) An insured shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by the insurer.

(6)(a) The insurer shall provide to the independent review organization conducting the review a copy of those records in its possession that are RELEVANT to the insured's medical condition and the review.

Records shall be used solely for the purpose of this division. At the request of the independent review organization, the insurer, insured, provider, or health care facility rendering health care services to the insured shall provide any additional information the independent review organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. the independent review organization shall submit the request to the insured and insurer. If a request is submitted orally or by electronic means to an insured or insurer, not later than five days after the request is submitted, the independent review organization shall provide written confirmation of the request. If the review was initiated by a provider or health care facility, a copy of the request shall be submitted to the provider or health care facility.

(b) An independent review organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. An independent review organization that does not make a decision for this reason shall notify the insured and the insurer that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An Oral or electronic notice shall be confirmed in writing not later than five days after the oral or electronic notice is made. If the review was initiated by a provider or health care facility, a copy of the notice shall be submitted to the provider or health care facility.

(7) the insurer may elect to cover the service requested and terminate the review. The insurer shall notify the insured and all other parties involved with the decision by mail, or with the consent or approval of the insured, by

electronic means.

(8) In making its decision, an independent review organization conducting the review shall take into account all of the following:

(a) Information submitted by the insurer, the insured, the insured's provider, and the health care facility rendering the health care service, including the following:

(i) The insured's medical records;

(ii) The standards, criteria, and clinical rationale used by the insurer to make its DECISION.

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the national institutes of health or any board recognized by the national institutes of health, the national cancer institute, the national academy of sciences, the United States food and drug ADMINISTRATION, the health care financing administration of the United States department of health and human services, and the agency for health care policy and RESEARCH;

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

(9)(a) In the case of an expedited review, the independent review organization shall issue a written decision not later than seven days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty days after the filing of the request. The independent review organization shall send a copy of its decision to the insurer and the insured. If the insured's provider or the health care facility rendering health care services to the insured requested the review, the independent review organization shall also send a copy of its decision to the insured's provider or the health care facility.

(b) The independent review organization's decision shall include a description of the insured's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.(e) The independent review organization shall base its decision on the information submitted under division (d)(8) of this section. In making its decision, the independent review organization shall consider safety, efficacy, appropriateness, and cost-effectiveness.(f) The insurer shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the insured's policy or certificate.Sec. 3923.68. (A) Each insurer shall establish a reasonable external, independent review process to examine the insurer's coverage decisions for insureds who meet all of the

following criteria:

(1) The insured has a terminal condition that, according to the current diagnosis of the insured's physician, has a high probability of causing death within two years.

(2) the insured requests a review not later than sixty days after receipt by the insured of notice from the superintendent of insurance under section 3923.66 of the Revised Code that making a determination requires resolution of a medical issue.

(3) The insured's physician certifies that the insured has the condition described in division (A)(1) of this section and any of the following situations are applicable:

(a) Standard therapies have not been effective in improving the condition of the insured.

(b) Standard therapies are not medically appropriate for the insured.

(c) There is no standard therapy covered by the insurer that is more beneficial than therapy described in division (A)(4) of this section.

(4) The insured's physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to the insured, in the physician's opinion, than standard therapies, or the insured has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

(5) The insured has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to division (A)(4) of this section, and has exhausted the insurer's internal review process.

(6) The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for the insurer's determination that the drug, device, procedure, or other therapy is experimental or investigational.

(B) a review shall be requested in writing, except that if the insured's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the insurer not later than five days after the oral or written request is submitted.

(C) The external, independent review process established by an insurer shall meet all of the following criteria:

(1) Except as provided in division (e) of this section, the process shall afford all insureds who meet the criteria set forth in division (A) of this

section the opportunity to have the insurer's decision to deny coverage of the recommended or requested therapy reviewed under the process. Each eligible insured shall be notified of that opportunity within thirty business days after the insurer denies coverage.

(2) The review shall be conducted by an independent review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code.

The independent review organization shall select a panel to conduct the review, which panel shall be composed of at least three physicians or other providers who, through clinical experience in the past three years, are experts in the treatment of the insured's medical condition and knowledgeable about the recommended or requested therapy.

In either of the following circumstances, an exception may be made to the requirement that the review be conducted by an expert panel composed of a minimum of three physicians or other providers:

(a) A review may be conducted by an expert panel composed of only two physicians or other providers if an insured has consented in writing to a review by the smaller panel.

(b) A review may be conducted by a single expert physician or other provider if only the expert physician or other provider is available for the review.

(3) Neither the insurer nor the insured shall choose, or control the choice of, the physician or other provider experts.

(4) the selected experts, any health care facility with which an expert is affiliated, and the independent review organization arranging for the experts' review shall not have any professional, familial, or financial affiliation with any of the following:

(a) The insurer or any officer, director, or managerial employee of the insurer;

(b) the insured, the insured's physician, or the practice group of the insured's physician;

(c) The health care facility at which the recommended or requested therapy would be provided;

(d) the development or manufacture of the principal drug, device, procedure, or therapy involved in the recommended or requested therapy.

However, experts affiliated with academic medical centers who provide health care services to insureds of the insurer may serve as experts on the review panel. Further, experts with staff PRIVILEGES at a health care facility that provides health care services to insureds of the insurer, as well as experts who have a contractual relationship with the insurer, but who

were not INVOLVED with the insurer's denial of coverage for the therapy under review, may serve as experts on the review panel. These nonaffiliation provisions do not preclude an insurer from paying for the experts' review, as specified in division (C)(5) of this section.

(5) Insureds shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by the insurer.

(6) The insurer shall provide to the independent review organization arranging for the experts' review a copy of those records in the insurer's possession that are relevant to the insured's medical condition and the review. The records shall be disclosed solely to the expert reviewers and shall be used solely for the purpose of this section. At the request of the expert reviewers, the insurer or the physician requesting the therapy shall provide any additional information that the expert reviewers request to complete the review. An expert reviewer is not required to render an opinion if the reviewer has not received any requested information that the reviewer considers necessary to complete the review.

(7)(a) IN THE CASE OF AN EXPEDITED REVIEW, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN SEVEN DAYS AFTER the FILING of THE REQUEST FOR REVIEW. IN ALL OTHER CASES, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN THIRTY DAYS AFTER THE FILING OF THE REQUEST. THE INDEPENDENT review organization SHALL SEND A COPY OF ITS DECISION TO THE insurer and the insured. IF THE insured's PROVIDER OR THE HEALTH CARE FACILITY RENDERING HEALTH CARE SERVICES TO THE insured REQUESTED THE review, THE INDEPENDENT review organization SHALL also SEND A COPY OF ITS DECISION TO THE insured's PROVIDER OR THE HEALTH CARE FACILITY.

(b) In conducting the review, the experts on the panel shall take into account all of the following:

(i) Information submitted by the insurer, the insured, and the insured's physician, including the insured's medical records and the standards, criteria, and clinical rationale used by the insurer to reach its coverage decision;

(ii) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations;

(iii) Relevant findings in peer-reviewed medical or scientific literature and published opinions of nationally recognized medical experts;

(iv) Clinical guidelines adopted by relevant national medical societies;

(v) SAFETY, EFFICACY, APPROPRIATENESS, AND COST

EFFECTIVENESS.

(8) Each expert on the panel shall provide the independent review organization with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely to be more beneficial to the insured than standard therapies.

(9) Each expert's opinion shall be presented in written form and shall include the following information:

(a) A description of the insured's condition;

(b) A description of the indicators relevant to 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 insured than standard therapies;

(c) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;

(d) A description of the insured's suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

(10) The independent review organization shall provide the insurer with the opinions of the experts. The insurer shall make the experts' opinions available to the insured and the insured's physician, upon request.

(11) The opinion of the majority of the experts on the panel, rendered pursuant to division (C)(8) of this section, is binding on the insurer with respect to that insured. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the insurer's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the insurer may, in its discretion, cover the therapy. However, any coverage provided pursuant to division (C)(11) of this section is subject to the terms, limitations, and conditions of the insured's policy or certificate with the insurer.

(12) The insurer shall have written policies describing the external, independent review process.

(D) If an insurer's initial denial of coverage for a therapy recommended or requested pursuant to division (a)(3) of this section is based upon an external, independent review of that therapy meeting the requirements of division (C) of this section, this section shall not be a basis for requiring a second external, independent review of the recommended or requested therapy.

(E) At any time during the external, independent review process, the insurer may elect to cover the recommended or requested health care service

and terminate the review. The insurer shall notify the insured and all other parties involved by mail or, with consent or approval of the insured, by electronic means.

(F) The insurer shall annually file a certificate with the superintendent of insurance certifying its compliance with the requirements of this section.

Sec. 3923.681. (A) If, after notice and hearing, the superintendent of insurance finds that an insurer has failed to comply with section 3923.66 or 3923.67 of the Revised Code, the superintendent may suspend or revoke the insurer's license to transact business within the state.

(B)(1) In lieu of the suspension or revocation of a license under division (A) of this section, the superintendent of insurance, pursuant to an adjudication hearing initiated and conducted in accordance with Chapter 119. of the Revised Code, or by consent of the insurer without an adjudication hearing, may levy an administrative penalty. The administrative penalty shall be in an amount determined by the superintendent, but the administrative penalty shall not exceed one hundred thousand dollars per violation. Additionally, the superintendent may require the insurer to correct any deficiency that may be the basis for the suspension or revocation of the insurer's license. All penalties collected shall be paid into the state treasury to the credit of the department of insurance operating fund.

(2) If the superintendent for any reason has cause to believe that any violation of section 3923.66 or 3923.67 of the Revised Code has occurred or is threatened, the superintendent may give notice to the insurer and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the suspected violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

Proceedings shall not be covered by any formal procedural requirements, and may be conducted in the manner the superintendent may consider appropriate under the circumstances.

(3)(a) The superintendent may issue an order directing an insurer or a representative of the insurer to cease and desist from engaging in any act or practice in violation of section 3923.67 or 3923.68 of the Revised Code. Within thirty days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of those sections have occurred. Such hearings shall be conducted in accordance with Chapter 119. of the Revised Code and judicial

review shall be available as provided by that chapter.

(b) If the superintendent has reasonable cause to believe that an order has been violated in whole or in part, the superintendent may request the attorney general to commence and prosecute any appropriate action or proceeding in the name of the state against the violators in the court of common pleas of Franklin county. The court in any such action or proceeding may levy civil penalties, not to exceed one hundred thousand dollars per violation, in addition to any other appropriate relief, including requiring a violator to pay the expenses reasonably incurred by the superintendent in enforcing the order. The penalties and fees collected shall be paid into the state treasury to the credit of the department of insurance operating fund.

Sec. 3923.69. Nothing in sections 3923.66 to 3923.68 of the Revised Code shall be construed to create a cause of action against any of the following:

(A) An employer that provides health care benefits to employees through an insurer;

(B) A clinical peer, medical expert, or independent review organization that participates in an external review under section 3923.67 or 3923.68 of the Revised Code;

(C) An insurer that provides coverage for benefits pursuant to section 3923.67 or 3923.68 of the Revised Code.

Sec. 3923.70. Consistent with the rules of evidence, a written decision or opinion prepared by an independent review organization under section 3923.67 or 3923.68 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Consistent with the rules of evidence, any party to a civil action related to an insurer's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

Sec. 3923.75. (A) AS USED IN SECTIONS 3923.75 TO 3923.79 OF THE REVISED CODE:

(1) "CLINICAL PEER" AND "PHYSICIAN" HAVE THE SAME MEANINGS AS IN SECTION 1751.77 OF THE REVISED CODE.

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a plan member with respect to health care

decisions.

(B) Sections 3923.75 to 3923.79 of the Revised Code do not apply to any public employee benefit plan covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(C) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for review from plan members who have been denied COVERAGE OF a health care service on the grounds that the service is not a service covered under the terms of the public employee benefit plan.

On receipt of a written request from a plan member OR AUTHORIZED PERSON, the superintendent shall consider whether the health care service is a service covered under the terms of the plan, except that the superintendent shall not conduct a review under this section unless the plan member has exhausted the plan's internal review process. The plan and the plan member OR AUTHORIZED PERSON shall provide the superintendent with any information REQUIRED BY THE SUPERINTENDENT THAT IS IN THEIR POSSESSION AND IS GERMANE TO THE REVIEW.

Unless THE SUPERINTENDENT is not able to do so because making the determination requires resolution of a medical issue, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the plan. The superintendent shall notify the plan member and the plan of its determination or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the superintendent notifies the plan that making the determination requires the resolution of a medical issue, the plan shall afford the plan member an opportunity for external review under section 3923.76 or 3923.77 of the Revised Code. If the superintendent notifies the plan that the health care service is not a covered service, the plan is not required to cover the service or afford the plan member an external review.

Sec. 3923.76. (A) Except as provided in divisions (B) and (C) of this section, a public employee benefit plan shall afford a plan member an OPPORTUNITY for an external review of a coverage denial when requested by the plan member or authorized person, if both of the following

are the case:

(1) The plan has denied, reduced, or terminated coverage for what would be a covered health care service except that the plan has determined that the health care service is not medically necessary.

(2) except in the case of EXPEDITED review, The proposed service, plus any ancillary services and follow-up care, will cost the plan member more than five hundred dollars if the proposed service is not covered by the plan.

external review shall be conducted in accordance with this section, except that if a plan member with a terminal condition meets all of the criteria of division (A) of section 3923.77 of the Revised Code, an external review shall be conducted under that section.

(B) A plan member need not be afforded a review under this section in any of the following circumstances:

(1) the superintendent of insurance has determined under section 3923.75 of the Revised Code that the health care service is not a service covered under the terms of the plan.

(2) the plan member has failed to exhaust the plan's internal review process.

(3) the plan member has previously been afforded an external review for the same denial of coverage, and no new clinical information has been submitted to the plan.

(C)(1) A plan may deny a request for an external review if it is requested later than sixty days after receipt by the plan member of NOTICE FROM the superintendent of insurance under section 3923.75 of the Revised Code that making the determination requires the resolution of a medical issue. An external review may be requested by the plan member, an authorized person, the plan member's provider, or a health care facility rendering health care service to the plan member. The plan member may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the plan member.

(2) An external review must be requested in writing, except that if the plan member has a condition that requires EXPEDITED review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan not later than five days after the request is made.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification from the plan member's provider or the health care facility rendering the health care

service to the plan member that the proposed service, plus any ancillary services and follow-up care, will cost the plan member more than five hundred dollars if the proposed service is not covered by the plan.

(3) For an expedited review, the plan member's provider must certify that the plan member's condition could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the plan member or, with respect to a pregnant woman, the health of the plan member or the unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(d) The procedures used in conducting an external review shall include all of the following:

(1) The review shall be conducted by an independent review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code.

(2) eXCEPT AS PROVIDED IN dIVISIONs (d)(3) and (4) of this section, neither the clinical peer nor any health care facility with which the clinical peer is affiliated shall have any professional, familial, or financial affiliation with any of the following:

(a) The plan or any officer, director, or managerial employee of the plan;

(b) The plan member, the plan member's provider, or the practice group of the plan member's provider;

(c) The health care facility at which the health care service requested by the plan member would be provided;

(d) the development or manufacture of the principal drug, device, procedure, or therapy proposed for the plan member.

(3) Division (d)(2) of this section does not prohibit a clinical peer from conducting a review under any of the following circumstances:

(a) The clinical peer is affiliated with an academic medical center that provides health care services to members of the plan.

(b) the clinical peer has staff privileges at a health care facility that provides health care services to members of the plan.

(c) The clinical peer has a contractual relationship with the plan but was not involved with the plan's coverage decision.

(4) Division (d)(2) of this section does not prohibit the plan from paying the independent review organization for the conduct OF the review.

(5) A plan member shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by the plan.

(6)(a) The plan shall provide to the independent review organization conducting the review a copy of those records in its possession that are RELEVANT to the plan member's medical condition and the review.

Records shall be used solely for the purpose of this division. At the request of the independent review organization, the plan, plan member, provider, or health care facility rendering health care services to the plan member shall provide any additional information the independent review organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. the independent review organization shall submit the request to the plan member and the plan. If a request is submitted orally or by electronic means to a plan member or plan, not later than five days after the request is submitted, the independent review organization shall provide written confirmation of the request. If the review was initiated by a provider or health care facility, a copy of the request shall be submitted to the provider or health care facility.

(b) An independent review organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. An independent review organization that does not make a decision for this reason shall notify the plan member and the plan that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An Oral or electronic notice shall be confirmed in writing not later than five days after the oral or electronic notice is made. If the review was initiated by a provider or health care facility, a copy of the notice shall be submitted to the provider or health care facility.

(7) The plan may elect to cover the service requested and terminate the review. The plan shall notify the plan member and all other parties involved with the decision by mail, or with the consent or approval of the plan member, by electronic means.

(8) In making its decision, an independent review organization conducting the review shall take into account all of the following:

(a) Information submitted by the plan, the plan member, the plan member's provider, and the health care facility rendering the health care service, including the following:

(i) The plan member's medical records;

(ii) The standards, criteria, and clinical rationale used by the plan to make its DECISION.

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the

national institutes of health or any board recognized by the national institutes of health, the national cancer institute, the national academy of sciences, the United States food and drug ADMINISTRATION, the health care financing administration of the United States department of health and human services, and the agency for health care policy and RESEARCH;

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

(9)(a) In the case of an expedited review, the independent review organization shall issue a written decision not later than seven days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty days after the filing of the request. The independent review organization shall send a copy of its decision to the plan and the plan member. If the plan member's provider or the health care facility rendering health care services to the plan member requested the review, the independent review organization shall also send a copy of its decision to the plan member's provider or the health care facility.

(b) The independent review organization's decision shall include a description of the plan member's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

(e) The independent review organization shall base its decision on the information submitted under division (d)(8) of this section. In making its decision, the independent review organization shall consider safety, efficacy, appropriateness, and cost-effectiveness.

(f) The plan shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the plan.

Sec. 3923.77. (A) Each public employee benefit plan shall establish a reasonable external review process to examine the plan's coverage decisions for plan members who meet all of the following criteria:

(1) The plan member has a terminal condition that, according to the current diagnosis of the plan member's physician, has a high probability of causing death within two years.

(2) the plan member requests a review not later than sixty days after receipt by the plan member of notice from the superintendent of insurance under section 3923.75 of the Revised Code that making a determination requires resolution of a medical issue.

(3) The plan member's physician certifies that the plan member has the condition described in division (A)(1) of this section and any of the

following situations are applicable:

(a) Standard therapies have not been effective in improving the condition of the plan member.

(b) Standard therapies are not medically appropriate for the plan member.

(c) There is no standard therapy covered by the plan that is more beneficial than therapy described in division (A)(4) of this section.

(4) The plan member's physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to the plan member, in the physician's opinion, than standard therapies, or the plan member has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

(5) The plan member has been denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested pursuant to division (A)(4) of this section, and has exhausted all internal appeals.

(6) The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for the plan's determination that the drug, device, procedure, or other therapy is experimental or investigational.

(B) A review shall be requested in writing, except that if the plan member's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the plan not later than five days after the oral or written request is submitted. For an expedited review, the plan member's provider must certify that the requested or recommended therapy would be significantly less effective if not promptly initiated.

(C) The external review process established by a plan shall meet all of the following criteria:

(1) Except as provided in division (e) of this section, the process shall afford all plan members who meet the criteria set forth in division (A) of this section the opportunity to have the plan's decision to deny coverage of the recommended or requested therapy reviewed under the process. Each eligible plan member shall be notified of that opportunity within thirty business days after the plan denies coverage.

(2) The review shall be conducted by an independent review organization assigned by the superintendent of insurance under section 3901.80 of the Revised Code. The independent review organization shall

select a panel to conduct the review, which panel shall be composed of at least three physicians or other providers who, through clinical experience in the past three years, are experts in the treatment of the plan member's medical condition and knowledgeable about the recommended or requested therapy. If the independent review organization retained by the plan is an academic medical center, the panel may include experts affiliated with or employed by the academic medical center.

In either of the following circumstances, an exception may be made to the requirement that the review be conducted by an expert panel composed of a minimum of three physicians or other providers:

(a) A review may be conducted by an expert panel composed of only two physicians or other providers if a plan member has consented in writing to a review by the smaller panel.

(b) A review may be conducted by a single expert physician or other provider if only the expert physician or other provider is available for the review.

(3) Neither the plan nor the plan member shall choose, or control the choice of, the physician or other provider experts.

(4) The selected experts, any health care facility with which an expert is affiliated, and the independent review organization arranging for the experts' review shall not have any professional, familial, or financial affiliation with any of the following:

(a) The plan or any officer, director, or managerial employee of the plan;

(b) The plan member, the plan member's physician, or the practice group of the plan member's physician;

(c) The health care facility at which the recommended or requested therapy would be provided;

(d) The development or manufacture of the principal drug, device, procedure, or therapy involved in the recommended or requested therapy. However, experts affiliated with academic medical centers who provide health care services to members of the plan may serve as experts on the review panel. Further, experts with staff PRIVILEGES at a health care facility that provides health care services to members of the plan, as well as experts who have a contractual relationship with the plan, but who were not INVOLVED with the plan's denial of coverage for the therapy under review, may serve as experts on the review panel. These nonaffiliation provisions do not preclude a plan from paying for the experts' review, as specified in division (C)(5) of this section.

(5) Plan members shall not be required to pay for any part of the cost of

the review. The cost of the review shall be borne by the plan.

(6) The plan shall provide to the independent review organization arranging for the experts' review a copy of those records in the plan's possession that are relevant to the plan member's medical condition and the review. The records shall be disclosed solely to the expert reviewers and shall be used solely for the purpose of this section. At the request of the expert reviewers, the plan or the physician requesting the therapy shall provide any additional information that the expert reviewers request to complete the review. An expert reviewer is not required to render an opinion if the reviewer has not received any requested information that the reviewer considers necessary to complete the review.

(7)(a) IN THE CASE OF AN EXPEDITED REVIEW, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN SEVEN DAYS AFTER the FILING of THE REQUEST FOR REVIEW. IN ALL OTHER CASES, THE INDEPENDENT review organization SHALL ISSUE A WRITTEN DECISION NOT LATER THAN THIRTY DAYS AFTER THE FILING OF THE REQUEST. THE INDEPENDENT review organization SHALL SEND A COPY OF ITS DECISION TO THE plan AND THE plan member. IF THE plan member'S PROVIDER OR THE HEALTH CARE FACILITY RENDERING HEALTH CARE SERVICES TO THE plan member REQUESTED THE review, THE INDEPENDENT review organization SHALL also SEND A COPY OF ITS DECISION TO THE plan member'S PROVIDER OR THE HEALTH CARE FACILITY.

(b) In conducting the review, the experts on the panel shall take into account all of the following:

(i) Information submitted by the plan, the plan member, and the plan member's physician, including the plan member's medical records and the standards, criteria, and clinical rationale used by the plan to reach its coverage decision;

(ii) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations;

(iii) Relevant findings in peer-reviewed medical or scientific literature and published opinions of nationally recognized medical experts;

(iv) Clinical guidelines adopted by relevant national medical societies;

(v) SAFETY, EFFICACY, APPROPRIATENESS, AND COST EFFECTIVENESS.

(8) Each expert on the panel shall provide the independent review organization with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely

to be more beneficial to the plan member than standard therapies.

(9) Each expert's opinion shall be presented in written form and shall include the following information:

(a) a description of the plan member's condition;

(b) A description of the indicators relevant to 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 plan member than standard therapies;

(c) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;

(d) A description of the plan member's suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

(10) The independent review organization shall provide the plan with the opinions of the experts. The plan shall make the experts' opinions available to the plan member and the plan member's physician, upon request.

(11) The opinion of the majority of the experts on the panel, rendered pursuant to division (C)(8) of this section, is binding on the plan with respect to that plan member. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the plan's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the plan may, in its discretion, cover the therapy. However, any coverage provided pursuant to division (C)(11) of this section is subject to the terms, limitations, and conditions of the plan.

(12) The plan shall have written policies describing the external review process.

(D) If a plan's initial denial of coverage for a therapy recommended or requested pursuant to division (a)(3) of this section is based upon an external review of that therapy meeting the requirements of division (C) of this section, this section shall not be a basis for requiring a second external review of the recommended or requested therapy.

(E) At any time during the external review process, the plan may elect to cover the recommended or requested health care service and terminate the review. The plan shall notify the plan member and all other parties involved by mail or, with consent or approval of the plan member, by electronic means.

(F) The plan shall annually file a certificate with the superintendent of

insurance certifying its compliance with the requirements of this section.

Sec. 3923.78. Nothing in sections 3923.75 to 3923.79 of the Revised Code shall be construed to create a cause of action against any of the following:

(A) An employer that provides health care benefits to employees through an insurer;

(B) A clinical peer, medical expert, or independent review organization that participates in an external review under section 3923.76 or 3923.77 of the Revised Code;

(C) A plan that provides coverage for benefits pursuant to section 3923.76 or 3923.77 of the Revised Code.

Sec. 3923.79. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under section 3923.76 or 3923.77 of the Revised Code shall be admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Consistent with the Rules of Evidence, any party to a civil action related to a plan's decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable medicare reimbursement standards established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

Sec. 5747.01. Except as otherwise expressly provided or clearly appearing from the context, any term used in this chapter has the same meaning as when used in a comparable context in the Internal Revenue Code, and all other statutes of the United States relating to federal income taxes.

As used in this chapter:

(A) "Adjusted gross income" or "Ohio adjusted gross income" means adjusted gross income as defined and used in the Internal Revenue Code, adjusted as provided in divisions (A)(1) to (17) of this section:

(1) Add interest or dividends on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities.

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States that are exempt from federal income taxes but not from state income taxes.

(3) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or

instrumentality of the United States to the extent included in federal adjusted gross income but exempt from state income taxes under the laws of the United States.

(4) Deduct disability and survivor's benefits to the extent included in federal adjusted gross income.

(5) Deduct benefits under Title II of the Social Security Act and tier 1 railroad retirement benefits to the extent included in federal adjusted gross income under section 86 of the Internal Revenue Code.

(6) Add, in the case of a taxpayer who is a beneficiary of a trust that makes an accumulation distribution as defined in section 665 of the Internal Revenue Code, the portion, if any, of such distribution that does not exceed the undistributed net income of the trust for the three taxable years preceding the taxable year in which the distribution is made. "Undistributed net income of a trust" means the taxable income of the trust increased by (a)(i) the additions to adjusted gross income required under division (A) of this section and (ii) the personal exemptions allowed to the trust pursuant to section 642(b) of the Internal Revenue Code, and decreased by (b)(i) the deductions to adjusted gross income required under division (A) of this section, (ii) the amount of federal income taxes attributable to such income, and (iii) the amount of taxable income that has been included in the adjusted gross income of a beneficiary by reason of a prior accumulation distribution. Any undistributed net income included in the adjusted gross income of a beneficiary shall reduce the undistributed net income of the trust commencing with the earliest years of the accumulation period.

(7) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal adjusted gross income for the taxable year, had the targeted jobs credit allowed and determined under sections 38, 51, and 52 of the Internal Revenue Code not been in effect.

(8) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent included in federal adjusted gross income.

(9) Add any loss or deduct any gain resulting from the sale, exchange, or other disposition of public obligations to the extent included in federal adjusted gross income.

(10) Regarding tuition credits purchased under Chapter 3334. of the Revised Code:

(a) Deduct the following:

(i) For credits that as of the end of the taxable year have not been refunded pursuant to the termination of a tuition payment contract under section 3334.10 of the Revised Code, the amount of income related to the

credits, to the extent included in federal adjusted gross income;

(ii) For credits that during the taxable year have been refunded pursuant to the termination of a tuition payment contract under section 3334.10 of the Revised Code, the excess of the total purchase price of the tuition credits refunded over the amount of refund, to the extent the amount of the excess was not deducted in determining federal adjusted gross income~~;~~.

(b) Add the following:

(i) For credits that as of the end of the taxable year have not been refunded pursuant to the termination of a tuition payment contract under section 3334.10 of the Revised Code, the amount of loss related to the credits, to the extent the amount of the loss was deducted in determining federal adjusted gross income;

(ii) For credits that during the taxable year have been refunded pursuant to the termination of a tuition payment contract under section 3334.10 of the Revised Code, the excess of the amount of refund over the purchase price of each tuition credit refunded, to the extent not included in federal adjusted gross income.

(11)(a) Deduct, ~~in the case of a self-employed individual as defined in section 401(c)(1) of the Internal Revenue Code and~~ to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer paid during the taxable year for ~~insurance that constitutes~~ medical care insurance and qualified long-term care insurance for the taxpayer, the taxpayer's spouse, and dependents. No deduction for medical care insurance under division (A)(11) of this section shall be allowed either to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's spouse ~~of the taxpayer. No deduction under division (A)(11) of this section shall be allowed to the extent that the sum of such deduction and any related deduction allowable in computing federal adjusted gross income for the taxable year exceeds the taxpayer's earned income, within the meaning of section 401(c) of the Internal Revenue Code, derived by the taxpayer from the trade or business with respect to which the plan providing the medical coverage is established.~~, or to any taxpayer who is entitled to, or on application would be entitled to, benefits under part A of Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended. FOR THE PURPOSES OF DIVISION (A)(11)(a) OF THIS SECTION, "SUBSIDIZED HEALTH PLAN" MEANS A HEALTH PLAN FOR WHICH THE EMPLOYER PAYS ANY PORTION OF THE plan's COST. THE DEDUCTION ALLOWED UNDER DIVISION (A)(11)(a) OF THIS

SECTION SHALL BE the NET OF ANY related PREMIUM REFUNDS, related premium REIMBURSEMENTS, OR related INSURANCE premium DIVIDENDS RECEIVED DURING THE TAXABLE YEAR.

(b) DEDUCT, TO THE EXTENT NOT OTHERWISE DEDUCTED OR EXCLUDED IN COMPUTING FEDERAL OR OHIO ADJUSTED GROSS INCOME DURING THE TAXABLE YEAR, THE AMOUNT THE TAXPAYER PAID DURING THE TAXABLE YEAR, NOT COMPENSATED FOR BY ANY INSURANCE OR OTHERWISE, FOR MEDICAL CARE OF THE TAXPAYER, THE TAXPAYER'S SPOUSE, AND DEPENDENTS, TO THE EXTENT THE EXPENSES EXCEED SEVEN AND ONE-HALF PER CENT OF THE TAXPAYER'S FEDERAL ADJUSTED GROSS INCOME.

(c) FOR PURPOSES OF DIVISION (A)(11) OF THIS SECTION, "MEDICAL CARE" HAS THE MEANING GIVEN IN SECTION 213 OF THE INTERNAL REVENUE CODE, SUBJECT TO THE SPECIAL RULES, LIMITATIONS, AND EXCLUSIONS SET FORTH THEREIN, AND "QUALIFIED LONG-TERM CARE" HAS THE SAME MEANING GIVEN IN SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE.

(12)(a) Deduct any amount included in federal adjusted gross income solely because the amount represents a reimbursement or refund of expenses that in ~~a previous~~ any year the taxpayer had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable United States department of the treasury regulations. THE DEDUCTION OTHERWISE ALLOWED UNDER DIVISION (A)(12)(a) OF THIS SECTION SHALL BE REDUCED TO THE EXTENT THE REIMBURSEMENT IS ATTRIBUTABLE TO AN AMOUNT THE TAXPAYER DEDUCTED UNDER THIS SECTION IN ANY TAXABLE YEAR.

(b) ADD ANY AMOUNT NOT OTHERWISE INCLUDED IN OHIO ADJUSTED GROSS INCOME FOR ANY TAXABLE YEAR TO THE EXTENT THAT THE AMOUNT IS ATTRIBUTABLE TO THE RECOVERY DURING THE TAXABLE YEAR OF ANY AMOUNT DEDUCTED OR EXCLUDED IN COMPUTING FEDERAL OR OHIO ADJUSTED GROSS INCOME IN ANY TAXABLE YEAR.

(13) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's adjusted gross income for a prior taxable year and did not qualify

for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year;

(b) It does not otherwise reduce the taxpayer's adjusted gross income for the current or any other taxable year.

(14) Deduct an amount equal to the deposits made to, and net investment earnings of, a medical savings account during the taxable year, in accordance with section 3924.66 of the Revised Code. The deduction allowed by division (A)(14) of this section does not apply to medical savings account deposits and earnings otherwise deducted or excluded for the current or any other taxable year from the taxpayer's federal adjusted gross income.

(15)(a) Add an amount equal to the funds withdrawn from a medical savings account during the taxable year, and the net investment earnings on those funds, when the funds withdrawn were used for any purpose other than to reimburse an account holder for, or to pay, eligible medical expenses, in accordance with section 3924.66 of the Revised Code;

(b) Add the amounts distributed from a medical savings account under division (A)(2) of section 3924.68 of the Revised Code during the taxable year.

(16) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that such amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal adjusted gross income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction of the taxpayer's federal adjusted gross income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(17) Deduct the amount contributed by the taxpayer to an individual development account program established by a county department of human services pursuant to sections 329.11 to 329.14 of the Revised Code for the purpose of matching funds deposited by program participants. On request of the tax commissioner, the taxpayer shall provide any information that, in the tax commissioner's opinion, is necessary to establish the amount deducted under division (A)(17) of this section.

(B) "Business income" means income arising from transactions, activities, and sources in the regular course of a trade or business and includes income from tangible and intangible property if the acquisition, rental, management, and disposition of the property constitute integral parts of the regular course of a trade or business operation.

(C) "Nonbusiness income" means all income other than business income and may include, but is not limited to, compensation, rents and royalties from real or tangible personal property, capital gains, interest, dividends and distributions, patent or copyright royalties, or lottery winnings, prizes, and awards.

(D) "Compensation" means any form of remuneration paid to an employee for personal services.

(E) "Fiduciary" means a guardian, trustee, executor, administrator, receiver, conservator, or any other person acting in any fiduciary capacity for any individual, trust, or estate.

(F) "Fiscal year" means an accounting period of twelve months ending on the last day of any month other than December.

(G) "Individual" means any natural person.

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(I) "Resident" means:

(1) An individual who is domiciled in this state, subject to section 5747.24 of the Revised Code;

(2) The estate of a decedent who at the time of death was domiciled in this state. The domicile tests of section 5747.24 of the Revised Code and any election under section 5747.25 of the Revised Code are not controlling for purposes of division (I)(2) of this section.

(J) "Nonresident" means an individual or estate that is not a resident. An individual who is a resident for only part of a taxable year is a nonresident for the remainder of that taxable year.

(K) "Pass-through entity" has the same meaning as in section 5733.04 of the Revised Code.

(L) "Return" means the notifications and reports required to be filed pursuant to this chapter for the purpose of reporting the tax due and includes declarations of estimated tax when so required.

(M) "Taxable year" means the calendar year or the taxpayer's fiscal year ending during the calendar year, or fractional part thereof, upon which the adjusted gross income is calculated pursuant to this chapter.

(N) "Taxpayer" means any person subject to the tax imposed by section 5747.02 of the Revised Code or any pass-through entity that makes the election under division (D) of section 5747.08 of the Revised Code.

(O) "Dependents" means dependents as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year or which the taxpayer would have been permitted to claim had the taxpayer filed a federal income tax return.

(P) "Principal county of employment" means, in the case of a nonresident, the county within the state in which a taxpayer performs services for an employer or, if those services are performed in more than one county, the county in which the major portion of the services are performed.

(Q) As used in sections 5747.50 to 5747.55 of the Revised Code:

(1) "Subdivision" means any county, municipal corporation, park district, or township.

(2) "Essential local government purposes" includes all functions that any subdivision is required by general law to exercise, including like functions that are exercised under a charter adopted pursuant to the Ohio Constitution.

(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax.

(S) "Taxable income" applies to estates only and means taxable income as defined and used in the Internal Revenue Code adjusted as follows:

(1) Add interest or dividends on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities;

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States that are exempt from federal income taxes but not from state income taxes;

(3) Add the amount of personal exemption allowed to the estate pursuant to section 642(b) of the Internal Revenue Code;

(4) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States that are exempt from state taxes under the laws of the United States;

(5) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal taxable income for the taxable year, had the targeted jobs credit allowed under sections 38, 51, and 52 of the Internal Revenue Code not been in effect;

(6) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent included in federal taxable income;

(7) Add any loss or deduct any gain resulting from sale, exchange, or other disposition of public obligations to the extent included in federal taxable income;

(8) Except in the case of the final return of an estate, add any amount deducted by the taxpayer on both its Ohio estate tax return pursuant to

section 5731.14 of the Revised Code, and on its federal income tax return in determining either federal adjusted gross income or federal taxable income;

(9)(a) Deduct any amount included in federal taxable income solely because the amount represents a reimbursement or refund of expenses that in a previous year the decedent had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable treasury regulations~~;~~. The deduction otherwise allowed under division (S)(9)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer or decedent deducted under this section in any taxable year.

(b) Add any amount not otherwise included in Ohio taxable income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio taxable income in any taxable year.

(10) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's taxable income or the decedent's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year.

(b) It does not otherwise reduce the taxpayer's taxable income or the decedent's adjusted gross income for the current or any other taxable year.

(11) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that the amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal taxable income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction in the taxpayer's federal taxable income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(T) "School district income" and "school district income tax" have the same meanings as in section 5748.01 of the Revised Code.

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) of this section, "public obligations," "purchase obligations," and "interest or interest equivalent" have the same meanings as in section 5709.76 of the Revised Code.

(V) "Limited liability company" means any limited liability company formed under Chapter 1705. of the Revised Code or under the laws of any

other state.

(W) "Pass-through entity investor" means any person who, during any portion of a taxable year of a pass-through entity, is a partner, member, shareholder, or investor in that pass-through entity.

(X) "Banking day" has the same meaning as in section 1304.01 of the Revised Code.

(Y) "Month" means a calendar month.

(Z) "Quarter" means the first three months, the second three months, the third three months, or the last three months of the taxpayer's taxable year.

(AA) Any term used in this chapter that is not otherwise defined in this section and that is not used in a comparable context in the Internal Revenue Code and other statutes of the United States relating to federal income taxes has the same meaning as in section 5733.40 of the Revised Code.

SECTION 2. That existing sections 1751.11, 1751.19, 1751.33, 1751.35, 1751.77, 1751.78, 1751.81, 1751.82, 1751.83, 1751.84, 1751.85, 1753.24, and 5747.01 of the Revised Code are hereby repealed.

SECTION 3. Sections 1 and 2 of this act, except for the amendment of sections 1751.11, 1751.33, and 5747.01 and the enactment of sections 1753.13 and 3923.65 of the Revised Code, shall take effect on May 1, 2000. The enactment of section 1753.13 and the amendment of sections 1751.11, 1751.33, and 5747.01 of the Revised Code shall take effect on the effective date of this section. The enactment of section 3923.65 of the Revised Code shall take effect 180 days after the effective date of this section.

SECTION 4. Section 3923.65 of the Revised Code applies only to policies issued, issued for delivery, or renewed in this state 180 days after the effective date of this section and thereafter.

SECTION 5. The amendment by this act of section 5747.01 of the Revised Code applies to taxable years beginning on or after January 1, 1999.

SECTION 6. It is the intent of the General Assembly that sections 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, and 3923.77 of the Revised Code, as enacted or amended by this act, provide health insuring corporation enrollees, insureds, and governmental plan members with a means for

resolving health care coverage disputes expeditiously and avoid the need for lengthy and expensive litigation.

SECTION 7. This act shall be known as "The Patient Protection Act of 1999."

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Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____