(129th General Assembly)
(Substitute House Bill Number 218)

AN ACT

To amend sections 1751.11, 1751.33, 1751.35, 1751.66, 1751.77, 1751.78, 1751.811, 1751.83, 1751.87, 1751.89, 3901.045, 3923.60, and 4731.36; to enact sections 3922.01 to 3922.23; and to repeal sections 1751.831, 1751.84, 1751.85, 1751.88, 3901.80, 3901.81, 3901.82, 3901.83, 3901.84, 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 use the compendia adopted by the United States Department of Health and Human Services to determine whether an insurer may exclude coverage for off-label drug usage and to revise the external review process used by health plan issuers.

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

SECTION 1. That sections 1751.11, 1751.33, 1751.35, 1751.66, 1751.77, 1751.78, 1751.811, 1751.83, 1751.87, 1751.89, 3901.045, 3923.60, and 4731.36 be amended and sections 3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 3922.07, 3922.08, 3922.09, 3922.10, 3922.11, 3922.12, 3922.13, 3922.14, 3922.15, 3922.16, 3922.17, 3922.18, 3922.19, 3922.20, 3922.21, 3922.22, and 3922.23 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 health 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 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 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 and deductibles;

(c) 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 a toll-free telephone number;

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment and deductible 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~~ 1751.83 and Chapter 3922. 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, 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, 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 medicare 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 medicaid recipients, 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 job and family 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 job and family services, or the department of administrative services.

Sec. 1751.33. (A) Each health insuring corporation shall provide to its subscribers a description of the health insuring corporation, its method of operation, its service area, its most recent provider list, 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~~ 1751.83 and Chapter 3922. of the Revised Code. A health insuring corporation may satisfy this requirement by delivering to its subscribers a document that identifies a web site where the subscriber may view this information. At the request of the subscriber, a health insuring corporation shall provide this information in hard copy 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 superintendent determines, 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~~ 1751.87 or Chapter 3922. 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. 1751.66. (A) No individual or group health insuring corporation policy, contract, or agreement that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia ~~specified in division (B)(1) of this section~~ adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets the criteria specified in division (B)~~(2)~~ of this section.

(B)~~(1) The compendia accepted for purposes of division (A) of this section are the following:~~

~~(a) The "AMA drug evaluations," a publication of the American medical association;~~

~~(b) The "AHFS (American hospital formulary service) drug information," a publication of the American society of health system pharmacists;~~

~~(c) "Drug information for the health care provider," a publication of the United States pharmacopoeia convention.~~

~~(2)~~ Medical literature may be accepted for purposes of division (A) of this section only if all of the following apply:

~~(a)~~(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's

safety and effectiveness for treatment of the indication for which it has been prescribed;

~~(b)~~(2) No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;

~~(c)~~(3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to Section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 (x)(t)(2)(B), as amended, as accepted peer-reviewed medical literature.

(C) Coverage of a drug required by division (A) of this section includes medically necessary services associated with the administration of the drug.

(D) Division (A) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States food and drug administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;

(2) Require coverage for experimental drugs not approved for any indication by the United States food and drug administration;

(3) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States food and drug administration;

(4) Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in a health insuring corporation contract;

(5) Prohibit a health insuring corporation from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.

(E) This section applies only to health insuring corporation policies, contracts, and agreements that are described in division (A) of this section and that are delivered, issued for delivery, or renewed in this state on or after July 1, 1997.

Sec. 1751.77. As used in sections 1751.77 to ~~1751.88~~ 1751.87 of the Revised Code, unless otherwise specifically provided or as otherwise required pursuant to applicable federal law or regulations:

(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 has been reviewed and, based upon the information provided, the health care service does not meet the 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.

(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 has been reviewed and, based upon the information provided, the health care service satisfies the requirements for benefit payment under the health insuring corporation's policy, contract, or agreement.

(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.

(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.

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

(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.

(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.

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

(L) "Prospective review" means utilization review that is conducted prior to an admission or a course of treatment.

(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.

(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.

(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.

(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 ~~1751.88~~ 1751.87 and Chapter 3922. 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 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 covering basic health care services.

(2) Nothing in sections 1751.77 to 1751.82 or section 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 ~~1751.88~~ 1751.87 and Chapter 3922. 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 ~~1751.88~~ 1751.87 and Chapter 3922. 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. 1751.811. 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~~ 3922.08 or ~~1751.85~~ 3922.10 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. 1751.83. 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~~ thirty 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 or in accordance with applicable preemptive

federal laws or regulations. 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~~ 3922.02 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~~ an external review under ~~section 1751.831, 1751.84, or 1751.85~~ Chapter 3922. 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~~ Chapter 3922. 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~~ Chapter 3922. 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. 1751.87. Nothing in sections 1751.77 to ~~1751.85~~ 1751.83 of the Revised Code shall be construed to create a cause of action against ~~any of the following:~~

~~(A) An~~ 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 of division (C)(11) of section 1751.85 of the Revised Code~~.

Sec. 1751.89. Sections 1751.77 to ~~1751.85~~ 1751.83 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 medicaid recipients;

(C) Coverage provided to participants of the children's buy-in program.

Sec. 3901.045. (A) The superintendent of insurance may receive documents and information, including otherwise confidential or privileged documents and information, from local, state, federal, and international regulatory and law enforcement agencies, from local, state, and federal prosecutors, and from the national association of insurance commissioners and its affiliates and subsidiaries, provided that the superintendent maintains as confidential or privileged any document or information received with notice or the understanding that the document or information is confidential or privileged under the laws of the jurisdiction that is the source of the document or information.

(B) The superintendent may also receive documents and information, including otherwise confidential or privileged documents and information, from the chief deputy rehabilitator, the chief deputy liquidator, other deputy rehabilitators and liquidators, and from any other person employed by, or acting on behalf of, the superintendent pursuant to Chapter 3901. or 3903. of the Revised Code, provided that the superintendent maintains as confidential or privileged any document or information received with the notice or understanding that the document or information is confidential or privileged, except that the superintendent may share and disclose such a document or information when authorized by other sections of the Revised Code.

(C) The superintendent has the authority to maintain as confidential or privileged the documents and information received pursuant to this section.

(D) The superintendent's authority to receive documents and information under this section, from the persons and subject to the conditions listed in this section, is not limited in any way by section 1751.19, 3901.36, 3901.44, 3901.48, 3901.70, ~~3901.83,~~ 3903.11, 3903.72, 3903.88, 3905.492, 3905.50, 3922.21, or 3999.36 of the Revised Code.

Sec. 3922.01. As used in this chapter:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care

setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a health care service is not a covered benefit;

(d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.

(C) "Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(G) "Emergency medical condition" has the same meaning as in section 1753.28 of the Revised Code.

(H) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(I) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence, based on a systematic review of the relevant research, in making decisions about the care of individuals.

(J) "Facility" means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(K) "Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

(L) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, 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; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(M) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

(N) "Health care provider" or "provider" means a health care professional or facility.

(O) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(P) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(Q) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to all of the following:

(1) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(2) The provision of health care services or health-related benefits to a covered person;

(3) Payment for the provision of health care services to or for a covered person.

(R) "Independent review organization" means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and is accredited pursuant to section 3922.13 of the Revised Code.

(S) "Medical or scientific evidence" means evidence found in any of the following sources:

(1) Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;

(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;

(4) The following standard reference compendia:

(a) The American hospital formulary service drug information;

(b) Drug facts and comparisons;

(c) The American dental association accepted dental therapeutics;

(d) The United States pharmacopoeia drug information.

(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:

(a) The federal agency for health care research and quality;

(b) The national institutes of health;

(c) The national cancer institute;

(d) The national academy of sciences;

(e) The centers for medicare and medicaid services;

(f) The federal food and drug administration;

(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.

(6) Any other medical or scientific evidence that is comparable.

(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.

(U) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.

(V) "Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(W) "Retrospective review" means a review conducted after services have been provided to a covered person.

(X) "Superintendent" means the superintendent of insurance.

(Y) "Utilization review" has the same meaning as in section 1751.77 of the Revised Code.

(Z) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3922.02. (A) A covered person may make a request for an external review of an adverse benefit determination.

(B) All requests for external review shall be made in writing, except when making a request for an expedited review under section 3922.09 of the Revised Code, by the covered person within one hundred eighty days of the date of the final adverse benefit determination in a form prescribed by the

superintendent. Requests for an expedited 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 health plan issuer no later than five days after the initial request was made.

(C) An adverse benefit determination shall be eligible for internal appeal or external review, regardless of how small the cost of the requested health care service related to the adverse benefit determination is.

Sec. 3922.03. (A) All health plan issuers shall implement an internal appeal process under which a covered person may appeal an adverse benefit determination. This process must be in compliance with the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119, as amended, and the associated regulations, as well as any other applicable state rules or federal regulations.

(B) Review of a final adverse benefit determination shall be through an external review under section 3922.08, 3922.09, or 3922.10 of the Revised Code.

(C) All health plan issuers shall provide notice to covered persons, pursuant to and in accordance with federal regulations, of all internal appeal processes, external review processes, the availability of any applicable office of health insurance assistance, ombudsman program, or other similar program in this state to assist consumers.

Sec. 3922.04. (A) Except as provided in division (E) of this section, a health plan issuer is not required to grant a request for a standard external review made under section 3922.08 or 3922.10 of the Revised Code until the covered person has exhausted the health plan issuer's internal appeal process.

(B) An internal appeal process shall be considered exhausted if a covered person has requested an internal appeal and has not received a written decision from the health plan issuer within the time frame required by 23 C.F.R. 2560.503-1 or the health plan issuer fails to adhere to all requirements of the internal appeals process.

(C) Notwithstanding division (B) of this section, the internal appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person so long as the health plan issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health plan issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health plan issuer and the covered person, and is not reflective of a pattern or practice of noncompliance, except that:

(1) If the health plan issuer denies a request for external review under this division, the covered person may request written explanation from the health plan issuer, and the health plan issuer shall provide the explanation within ten days, including a specific description of its bases, if any, for asserting that the delay should not cause the internal appeals process to be considered exhausted;

(2) The covered person may request review by the superintendent of the health plan issuer's explanation provided under division (C)(1) of this section and if the superintendent affirms the health plan issuer's explanation, the covered person may, within ten days of the superintendent's notice of decision, resubmit and pursue the internal appeal process. Time periods for refiling the internal appeal shall begin to run upon receipt of such notice by the covered person.

(D) Notwithstanding division (B) of this section, a covered person shall not make a request for an external review of an adverse benefit determination involving a retrospective review determination made pursuant to a utilization review until the covered person has exhausted the health plan issuer's internal appeals process.

(E) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health plan issuer's internal appeals procedures whenever the health plan issuer agrees to waive the exhaustion requirement. If the internal appeal process is waived, the covered person may file a request in writing for a standard external review under section 3922.08 or 3922.10 of the Revised Code.

(F) Notwithstanding any other section in this chapter, health plan issuers offering individual health insurance coverage, including coverage offered to individuals through nonemployer groups shall not require more than one level of internal appeal before the individual may request an external review.

Sec. 3922.05. (A) A health plan issuer shall afford the opportunity for an external review by an independent review organization for an adverse benefit determination if the determination involved a medical judgment or if the decision was based on any medical information, pursuant to the following sections:

(1) Section 3922.08 of the Revised Code for a standard review;

(2) Section 3922.09 of the Revised Code for an expedited review;

(3) Section 3922.10 of the Revised Code for reviews involving experimental procedures.

(B) A health plan issuer shall afford the opportunity for an external review by the superintendent of insurance for an adverse benefit

determination by the health plan issuer based on a contractual issue that did not involve a medical judgment or any medical information, pursuant to section 3922.11 of the Revised Code.

(C) For an adverse benefit determination in which emergency medical services have been determined to be not medically necessary or appropriate after an external review pursuant to division (A) of this section, the health plan issuer shall afford the covered person the opportunity for an external review by the superintendent of insurance, based on the prudent layperson standard, pursuant to section 3922.11 of the Revised Code.

(D) Upon receipt of a request for an external review from a covered person, the health plan issuer shall review it for completeness as prescribed under any associated rules, policies, or procedures adopted by the superintendent.

(1) If the request is complete, the health plan issuer shall initiate an external review in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance and shall notify the covered person in writing, in a form specified by the superintendent of insurance, that the request is complete. This notification shall include both of the following:

(a) The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information;

(b) Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, a statement that the covered person may, with ten business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

(2) If the request for an external review is not complete, the health plan issuer shall, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, inform the covered person in writing, including what information is needed to make the request complete.

(E)(1) If the health plan issuer denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the health plan issuer shall notify the covered person in writing of both of the following:

(a) The reason for the denial;

(b) That the denial may be appealed to the superintendent.

(2) If the health plan issuer denies a request for external review on the basis that the adverse benefit determination is not eligible for an external

review, the covered person may appeal the denial to the superintendent of insurance.

(3) Regardless of a determination made by a health plan issuer, the superintendent of insurance may determine that a request is eligible for external review. The superintendent's determination shall be made in accordance with the terms of the covered person's benefit plan and shall be subject to all applicable provisions of this chapter.

(F)(1) If an external review of an adverse benefit determination is granted, the superintendent, according to any rules, policies, or procedures adopted by the superintendent shall assign an independent review organization from the list of organizations maintained by the superintendent under section 3922.13 of the Revised Code to conduct the external review and shall notify the health plan issuer of the name of the assigned independent review organization.

(2) The assignment of an approved independent review organization shall be done on a random basis from those independent review organizations qualified to conduct the review in question based on the nature of the health care service that is the subject of the adverse benefit determination.

(3) The superintendent of insurance shall not choose an independent review organization with a conflict of interest, as prescribed under section 3922.14 of the Revised Code.

(G) In its review of an adverse benefit determination under section 3922.08, 3922.09, or 3922.10 of the Revised Code, an assigned independent review organization is not bound by any decisions or conclusions reached by the health plan issuer during its utilization review process or internal appeals process. The organization is not required to, but may, accept and consider additional information submitted after the end of the ten-business-day period described in division (D)(1)(b) of this section.

(H)(1) An independent review organization assigned to review an adverse benefit determination shall provide written notice of its decision to either uphold or reverse the determination within thirty days of receipt of a request for a standard review or a standard review involving an experimental or investigational treatment, or within seventy-two hours of receipt of an expedited request.

(2) The written notice shall be sent to all of the following:

(a) The covered person;

(b) The health plan issuer;

(c) The superintendent of insurance.

(3) The written notification shall include all of the following:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization was assigned by the superintendent of insurance to conduct the external review;

(c) The dates over which the external review was conducted;

(d) The date on which the independent review organization's decision was made;

(e) The rationale for its decision;

(f) References to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision.

(I) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.

Sec. 3922.06. Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, an independent review organization shall forward upon receipt a copy of any information received from a covered person pursuant to division (D)(1) of section 3922.05 of the Revised Code, as well as any other information received from the covered person, to the health plan issuer.

Upon receipt of that information or the information described in division (K) of section 3922.10 of the Revised Code, a health plan issuer may reconsider its adverse benefit determination and provide coverage for the health service in question.

Reconsideration of an adverse benefit determination by a health plan issuer receipt of information under this section shall not delay or terminate an external review.

If a health plan issuer reverses an adverse benefit determination under this section, the health plan issuer shall notify, in writing and within one business day of making such a decision, the covered person, the assigned independent review organization, and the superintendent of insurance.

Upon receipt of such a notification, the assigned independent review organization shall terminate the associated external review.

Sec. 3922.07. In addition to the information provided under division (D)(1)(b) of section 3922.05, division (B) of section 3922.08, division (C) of section 3922.09, and division (D) of section 3922.10 of the Revised Code, an assigned independent review organization, to the extent that such documents are available and appropriate, shall consider all of the following when conducting its review:

(A) The covered person's medical records;

(B) The attending health care professional's recommendation;

(C) Consulting reports from appropriate health care professionals and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;

(D) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of the plan;

(E) The most appropriate practice guidelines, including evidence-based standards, and practice guidelines developed by the federal government, and national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization;

(G) The opinion of the independent review organization's clinical reviewer or reviewers after considering the other sources described in this section.

Sec. 3922.08. (A) The provisions of this section apply only to standard reviews, which are not expedited and do not involve an experimental or investigational treatment.

(B) Within five days after the receipt of a request for an external review that is complete and valid, the health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination.

(C) An external review shall not be delayed due to failure on the part of the health plan issuer to provide the information required under division (B) of this section.

(D)(1) An independent review organization may reverse an adverse benefit determination if the information required under division (B) of this section is not provided in the allotted time. The independent review organization may also grant a request from the health plan issuer for more time to provide the required information.

(2) If an adverse benefit determination is reversed under division (D)(1) of this section, the independent review organization shall notify, within one business day of making the decision, the covered person, the health plan issuer, and the superintendent of insurance.

Sec. 3922.09. (A) A covered person may make a request for an expedited external review, except as provided in division (J) of this section:

(1) After an adverse benefit determination, if both of the following apply:

(a) The covered person's treating physician certifies that the adverse

benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person if treated after the time frame of an expedited internal review;

(b) The covered person has filed a request for an expedited internal review.

(2) After a final adverse benefit determination, if either of the following apply:

(a) The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of a standard external review;

(b) The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

(B) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division (B) of this section. The health plan issuer shall immediately notify the covered person of its determination in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.

(C) If a request for an expedited review is complete and eligible, the health plan issuer shall immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization electronically, or by telephone, facsimile, or other available expeditious method.

(D) In addition to the information transmitted under division (D) of this section, the assigned independent review organization shall also consider relevant information as required under section 3922.07 of the Revised Code.

(E) As expeditiously as the covered person's medical condition requires, but no more than seventy-two hours after being assigned an expedited, external review, the assigned independent review organization shall uphold or reverse the adverse benefit determination.

(F) If a health plan issuer fails to provide the documents and information as required in division (D) of this section, the independent review organization shall not delay the external review and may accordingly reverse the adverse benefit determination.

(G) An independent review organization shall promptly notify the covered person, health plan issuer, and superintendent of insurance of any decision made under this section. If such a notice is not made in writing, the independent review organization, shall provide, within forty-eight hours of making the decision, written confirmation, including the information required under division (H)(3) of section 3922.05 of the Revised Code, of its decision to the covered person, the health plan issuer, and the superintendent of insurance.

(H) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.

(I) An expedited, external review may not be provided for retrospective final adverse benefit determinations.

Sec. 3922.10. The provisions of this section apply only to external reviews that involve an experimental or investigational treatment.

(A) A covered person may request an external review of an adverse benefit determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the covered person's benefit plan.

(B) To be eligible for an external review under this section, a covered person's treating physician shall certify that one of the following situations is applicable:

(1) Standard health care services have not been effective in improving the condition of the covered person;

(2) Standard health care services are not medically appropriate for the covered person;

(3) There is no available standard health care services covered by the health plan issuer that is more beneficial than requested health care service.

(C)(1) A covered person may request orally or by electronic means an expedited review under this section if the person's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

(2) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division (B) of this section. The health plan issuer shall immediately notify the covered person of its determination in accordance with any associated

rules adopted by the superintendent of insurance.

(D) The health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination within whichever of the following applies:

(1) Within five days after the receipt of a request for an external review;

(2) For an expedited external review, immediately by telephone, facsimile, or any other available expeditious method.

(E) An independent review organization assigned by the superintendent of insurance under division (F) of section 3922.05 of the Revised Code shall do both of the following:

(1) Select at least one clinical reviewer, pursuant to divisions (F) and (G) of this section to conduct the external review;

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

(F) In selecting clinical reviewers under division (E) of this section, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 3922.15 of the Revised Code, and through clinical experience in the last three years, are experts in the treatment of the covered person's condition and have knowledge of the requested health care service.

(G) Neither the covered person, nor the health plan issuer, shall choose or have any influence over the choice of the clinical reviewer or reviewers chosen under division (E) of this section.

(H)(1) Each chosen clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the adverse benefit determination should be upheld or reversed.

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

(3) Any such opinion shall be in writing and shall include all of the following information:

(a) A description of the covered person's condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to the covered person than any available standard health care service, and that the adverse risks of the requested health care service would not be substantially greater than those of available standard health care services;

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard considered;

(e) Information on whether the reviewer's rationale for the opinion is based on division (L)(2) or (L)(3) of this section.

(I) An external review shall not be delayed due to failure on the part of the health plan issuer to provide the information required under division (D) of this section.

(J)(1) An independent review organization may reverse an adverse benefit determination, if the information required under division (D) of this section is not provided in the allotted time. The external review committee may also grant a request from the health plan issuer for more time to provide the required information.

(2) If an adverse benefit determination is reversed under division (J)(1) of this section, the independent review organization shall immediately notify the covered person, the health plan issuer, and the superintendent of insurance.

(K)(1) Each clinical reviewer shall review all of the information received pursuant to division (D) of this section, as well as any other information submitted in writing by the covered person pursuant to division (D) of section 3922.05 of the Revised Code.

(2) In addition to the documents and information provided pursuant to division (D) of this section and division (D) of section 3922.05 of the Revised Code, each clinical reviewer shall consider the following:

(a) Information required under section 3922.07 of the Revised Code;

(b) Whether the requested health care service has been approved by the federal food and drug administration, if applicable, for the condition;

(c) Whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested health care service is more likely than not to be beneficial to the covered person than any available standard health care service, and that the adverse risks of the requested health care service would not be substantially greater than those of available standard health care services.

(L) Within one business day after the receipt of any such information submitted by the covered person in accordance with division (K)(1) of this section, the independent review organization shall forward the information to the health plan issuer. Upon receipt of any such forwarded information in accordance with division (K)(1) of this section, a health plan issuer may reconsider its adverse benefit determination under section 3922.06 of the Revised Code.

(M)(1) Within thirty days after the date of receipt of a request for a

standard external review, or within seventy-two hours of receipt of a request for an expedited external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to the covered person, the health plan issuer, and the superintendent of insurance.

(2)(a) If a majority of the clinical reviewers recommend that the requested health care service should be covered, the independent review organization shall make a decision to reverse the health plan issuer's adverse benefit determination.

(b) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health plan issuer's adverse benefit determination.

(c)(i) If the clinical reviewers are evenly split as to whether the adverse benefit determination should be reversed or upheld, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to this division.

(ii) The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to this section.

(iii) The selection of the additional clinical reviewer under this division shall not extend the time within which the assigned independent review organization is required to make a decision.

(3) The independent review organization shall include in the notice provided pursuant to division (M)(1) of this section all of the following:

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for that recommendation;

(c) The date the independent review organization was assigned by the superintendent to conduct the external review;

(d) The dates over which the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision;

(g) The rationale for its decision.

(N) Upon receipt of a notice of a decision by an independent review organization pursuant to division (M)(1) of this section reversing the

adverse benefit determination, a health plan issuer shall immediately provide coverage of the requested health care service in question.

Sec. 3922.11. (A) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for external review for adverse benefit determinations where the determination by the health plan issuer was based on a contractual issue and did not involve a medical judgment or a determination based on any medical information, except for emergency services, as specified in division (C) of section 3922.05 of the Revised Code.

(B) A health plan issuer shall submit a request for external review pursuant to division (B) or (C) of section 3922.05 of the Revised Code to the superintendent, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.

(C) On receipt of a request from a health plan issuer, the superintendent shall consider whether the health care service is a service covered under the terms of the covered person's policy, contract, certificate, or agreement, except that the superintendent shall not conduct a review under this section unless the covered person has exhausted the health plan issuer's internal review process, pursuant to sections 3922.03 and 3922.04 of the Revised Code. The health plan issuer and covered person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

(D) Unless the superintendent is not able to do so because making the determination requires a medical judgement or a determination based on medical information, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the covered person's contract, policy, certificate, or agreement. The superintendent shall notify the covered person, and the health plan issuer of the superintendent's determination.

(E) If the superintendent notifies the health plan issuer that making the determination requires a medical judgement or a determination based on medical information, the health plan issuer shall initiate an external review under this chapter.

(F) If the superintendent determines that the health service is a covered service, the health plan issuer shall cover the service.

(G) If the superintendent determines that the health care service is not a covered service, the health plan issuer is not required to cover the service or afford the enrollee an external review.

Sec. 3922.12. (A) An external review decision is binding on the health plan issuer except to the extent the health plan issuer has other remedies

available under applicable state law, or unless the superintendent of insurance determines that, due to the facts and circumstances of an external review, a second external review is required.

(B) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law, or unless the superintendent determines that, due to the facts and circumstances of an external review, a second external review is required.

(C) A covered person may not file a subsequent request for external review involving the same adverse benefit determination for which the covered person has already received an external review decision pursuant to this chapter, except in the event that new medical or scientific evidence is submitted to the health plan issuer.

Sec. 3922.13. The superintendent shall accredit independent review organizations as prescribed by this section.

(A) The superintendent shall develop an application form to accredit and renew accreditation of an independent review organization.

(B) An independent review organization seeking to be accredited by the superintendent, or to renew its accreditation, shall submit the application form and include with the form all documentation and information necessary for the superintendent to determine if the independent review organization satisfies the minimum qualifications established under section 3922.14 of the Revised Code.

(C)(1) Except as provided in division (C)(2) of this section, an independent review organization is eligible for accreditation by the superintendent under this section only if it is accredited by a nationally recognized private accrediting entity that the superintendent has determined has accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under section 3922.14 of the Revised Code.

(2) The superintendent may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity, if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(D) An independent review organization shall apply to renew its accreditation on an annual basis.

(E) If the superintendent determines that an independent review organization has lost its accreditation by a nationally recognized private accrediting entity or no longer satisfies the minimum requirements established under section 3922.14 of the Revised Code, the superintendent

shall revoke the independent review organization's accreditation and shall remove the independent review organization from the list of independent review organizations approved to conduct external reviews.

(F) The superintendent shall maintain and periodically update a list of accredited independent review organizations.

Sec. 3922.14. (A) To be accredited by the superintendent of insurance to conduct external reviews under section 3922.13 of the Revised Code, in addition to the requirements provided in section 3922.13 of the Revised Code and any associated rules adopted by the superintendent, an independent review organization shall do all of the following:

(1) Develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter, including a quality assurance mechanism that does all of the following:

(a) Ensures that external reviews are conducted within the time frames prescribed under this chapter and that the required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization;

(c) Ensures that chosen clinical reviewers are suitably matched according to their area of expertise to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this requirement;

(d) Ensures the confidentiality of medical and treatment records and clinical review criteria;

(e) Ensures that any person employed by, or who is under contract with, the independent review organization adheres to the requirements of this chapter.

(2) Maintain a toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-days-a-week basis related to external reviews that is capable of accepting, recording, and providing appropriate instruction to incoming telephone callers during other than normal business hours;

(3) Agree to maintain and provide to the superintendent, upon request and in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, the information prescribed in section 3922.17 of the Revised Code.

(B) An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a benefit plan, a national, state or local trade association of benefit plans, or a national, state, or local trade association of health care providers.

(C)(1) Neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material, professional, familial, or financial affiliation with any of the following:

(a) The health plan issuer that is the subject of the external review, or any officer, director, or management employee of the health plan issuer;

(b) The covered person whose treatment is the subject of the external review;

(c) The health care provider, or the health care provider's medical group or independent practice association, recommending the health care service or treatment that is the subject of the external review;

(d) The facility at which the recommended health care service would be provided;

(e) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) The superintendent may make a determination as to whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of division (C)(1) of this section. In making this determination, the superintendent may take into consideration situations where an independent review organization, or a clinical reviewer, may have an apparent conflict of interest, but that the characteristics of the relationship or connection in question are such that they do not fall under the definition of conflict of interest provided under division (D)(1) of this section. If the superintendent determines that a conflict of interest exists, the superintendent shall disallow an independent review organization or a clinical reviewer from conducting the external review in question. Such determinations related to conflicts of interest are the sole discretion of the superintendent of insurance.

(D)(1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the superintendent has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for accreditation by the superintendent under section 3922.14 of the Revised Code.

(2) The superintendent shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum

qualifications established under this section. The superintendent may accept a review conducted by the national association of insurance commissioners for the purpose of the determination under this division.

(3) Upon request, a nationally recognized, private accrediting entity shall make its current independent review organization accreditation standards available to the superintendent or the national association of insurance commissioners in order for the superintendent to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The superintendent may exclude any private accrediting entity that is not reviewed by the national association of insurance commissioners.

(E) An independent review organization shall be unbiased in its review of adverse benefit determinations and shall establish and maintain written procedures to ensure that it is unbiased.

Sec. 3922.15. All clinical reviewers assigned by an independent review organization to conduct external reviews shall have the same license as the health care provider of the service in question, and shall be physicians or other appropriate health care providers who meet all of the following minimum qualifications:

(A) Be an expert in the treatment of the medical condition that is the subject of the external review;

(B) Be knowledgeable about the requested health care service through clinical experience, within the last three years, treating patients with the same, or a similar, medical condition;

(C) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;

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

Sec. 3922.16. (A) Nothing in this chapter shall be construed to create a cause of action against any of the following:

(1) An employer that provides health care benefits to employees through a health plan issuer;

(2) A clinical reviewer, medical expert, or independent review organization that participates in an external review under this chapter;

(3) A health plan issuer that provides coverage for benefits pursuant to

this chapter.

(B) An independent review organization and any medical expert or clinical reviewer an independent review organization uses in conducting an external review under this chapter 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.

(C) 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 this chapter.

Sec. 3922.17. (A)(1) An independent review organization assigned pursuant to sections 3922.08, 3922.09, or 3922.10 of the Revised Code to conduct an external review shall maintain written records in accordance with the associated rules established by the superintendent, in the aggregate by state, and by the health plan issuer, on all external reviews requested and conducted during a calendar year.

Each independent review organization shall submit this information to the superintendent, upon request, in a report in the format specified by the superintendent that shall include, in the aggregate by state and for each health plan issuer, all of the following:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number upholding and the number reversing an adverse benefit determination;

(c) The average length of time for a resolution;

(d) A summary of the types of requested health care services or cases for which an external review was sought;

(e) The number of external reviews that were terminated as the result of a reconsideration by the health plan issuer of an adverse benefit determination after the receipt of additional information from the covered person under section 3922.05 of the Revised Code;

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

(g) The medical specialty, or the type, of clinical reviewer used to conduct each external review, as related to the specific medical condition of the covered person;

(h) Any other information the superintendent may request or require.

(2) The independent review organization shall retain the written records required under division (A)(1) of this section for at least three years.

(B) A health plan issuer shall maintain written records on all requests made for an external review under this chapter and shall provide all such information as required by any associated rules, policies, or procedures adopted by the superintendent of insurance. A health plan issuer shall maintain written records on all requests for external review for at least three years.

(C) 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. 3922.18. The health plan issuer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the external review, including the cost of any external review that is required at the direction of the superintendent.

If the superintendent determines that, due to the facts and circumstances of an external review, a second external review is required, the health plan issuer shall pay the costs of the second review.

Sec. 3922.19. (A) Each health plan issuer shall include a description of its external review procedures, including the superintendent's contractual review, in, or attached to, the policy, certificate, membership booklet, or outline of coverage, or other evidence of coverage it provides to covered persons. This disclosure shall be in a form prescribed by the superintendent in any associated rules, policies, or procedures.

(B) The disclosure required by division (A) of this section shall include a statement that informs the covered person of the covered person's right to file a request for an external review of an adverse benefit determination with the health plan issuer. The statement shall do all of the following:

(1) Explain that external review is available when the adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, and level of care or effectiveness;

(2) Include the telephone number and address of the superintendent

(3) Inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of the covered person's medical records as necessary to conduct the external review.

(C)(1) When a health plan issuer notifies a covered person of an adverse benefit determination, the health plan issuer shall also notify the covered person, in writing, of the covered person's right to request an external

review, pursuant to section 3922.08, 3922.09, 3922.10, or 3922.11 of the Revised Code.

(2) As part of the written notice required under division (C)(1) of this section, a health plan issuer shall include all of the following:

(a) Information sufficient to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;

(b) A description of the reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;

(c) A description of the health plan issuer's standard, if any, that was used in making the determination;

(d) A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal and an external review;

(e) Disclosure of the availability of assistance from the superintendent with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the superintendent's office of consumer services.

(3) In the case of a notice of a final adverse benefit determination subsequent to an internal appeal, in addition to the information required under division (C)(2) of this section, the notice must also include a discussion of the decision.

(4) Any written notice provided under division (C) of this section shall be in a form prescribed by the superintendent of insurance.

(D) For an adverse benefit determination that is not a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:

(1) If the covered person's treating physician certifies in writing that the covered person has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.

(2) If the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care

service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse benefit determination would be significantly less effective if not promptly initiated, the covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 or 3922.10 of the Revised Code.

(3) If the covered person has requested an internal appeal and the health plan issuer has not issued a written decision to the covered person within thirty days following the date the covered person files the request, and the covered person has not requested or agreed to a delay, the covered person may file a request for external review pursuant to section 3922.08 of the Revised Code and may be considered to have exhausted the health plan issuer's internal appeals process for purposes of section 3922.04 of the Revised Code.

(E) For a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:

(1) A written request for an external review must be submitted to the health plan issuer within one hundred eighty days after the date of the notice of final adverse benefit determination;

(2) If the covered person's treating physician certifies in writing that the covered person has a medical condition for which the time frame for completion of a standard external review pursuant to section 3922.08 of the Revised Code would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review pursuant to section 3922.09 of the Revised Code.

(3)(a) If the final adverse benefit determination concerns a health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person may request an expedited external review pursuant to section 3922.09 of the Revised Code.

(b) If the final adverse benefit determination concerns denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person may file a request for an external review to be conducted pursuant to section 3922.10 of the Revised Code, or if the covered person's treating physician certifies in writing that the recommended or requested health care service that is the subject of the request would be significantly less effective if not promptly initiated, the covered person may request an

expedited external review to be conducted under section 3922.10 of the Revised Code.

(F)(1) In addition, any information required to be provided under divisions (D) and (E) of this section, the health plan issuer shall include a description of both the standard and expedited external review procedures the health plan issuer is required to produce pursuant to this chapter, highlighting in the external review procedures the sections of the Revised Code that give the covered person the opportunity to submit additional information.

(2) The health plan issuer shall also include any forms used to process an external review, including an authorization form, or other document approved by the superintendent that complies with the requirements of 45 C.F.R. 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health plan issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are related in any manner to the external review.

Sec. 3922.20. Consistent with the Rules of Evidence, a written decision or opinion prepared by an independent review organization under this chapter 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. 3922.21. (A) When a record containing information pertaining to the medical history, diagnosis, prognosis, or medical condition of a covered person is provided to the superintendent of insurance for any reason under this chapter or sections 1751.77 to 1751.87 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 3922.17 of the Revised Code.

(B) Notwithstanding division (A) of this section, the superintendent may share a record that is the subject of this section in connection with the

investigation or prosecution of any illegal or criminal activity with the chief deputy rehabilitator, the chief deputy liquidator, other deputy rehabilitators and liquidators, and any other person employed by, or acting on behalf of, the superintendent pursuant to Chapter 3901. or 3903. of the Revised Code, with other local, state, federal, and international regulatory and law enforcement agencies, with local, state, and federal prosecutors, and with the national association of insurance commissioners and its affiliates and subsidiaries, provided that the recipient agrees to maintain the confidential or privileged status of the confidential or privileged record and has authority to do so.

(C) Nothing in this section shall prohibit the superintendent from receiving records in accordance with section 3901.045 of the Revised Code.

(D) The superintendent may enter into agreements governing the sharing and use of records consistent with the requirements of this section.

(E) No waiver of any applicable privilege or claim of confidentiality in the records that are the subject of this section shall occur as a result of sharing or receiving records as authorized in divisions (B) and (C) of this section.

Sec. 3922.22. The superintendent may adopt rules under Chapter 119. of the Revised Code to carry out the purposes of this chapter and shall prescribe forms relating to notices, appeals, and requests for external review under this chapter.

Sec. 3922.23. A violation of this chapter shall be an unfair or deceptive act or practice under sections 3901.19 to 3901.26 of the Revised Code. Additionally, health plan issuers holding a certificate of authority from the superintendent are also subject to the following:

(A) If, after notice and hearing, the superintendent of insurance finds that a health plan issuer has failed to comply with the requirements of this chapter, the superintendent may suspend or revoke the health plan issuer'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 health plan issuer 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 health plan issuer to correct any deficiency that may be the basis for the suspension or revocation of the health plan issuer'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 the requirements of this chapter has occurred or is threatened, the superintendent may give notice to the health plan issuer 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 a health plan issuer or a representative of the issuer to cease and desist from engaging in any act or practice in violation of the requirements of this chapter. 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. 3923.60. (A) Notwithstanding section 3901.71 of the Revised Code, no group or individual policy of sickness and accident insurance that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and

effective for treatment of that indication in one or more of the standard medical reference compendia ~~specified in division (B)(1) of this section~~ adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets the criteria specified in division (B)~~(2)~~ of this section.

(B)~~(1) The compendia accepted for purposes of division (A) of this section are the following:~~

~~(a) The "AMA drug evaluations," a publication of the American medical association;~~

~~(b) The "AHFS (American hospital formulary service) drug information," a publication of the American society of health system pharmacists;~~

~~(c) "Drug information for the health care provider," a publication of the United States pharmacopeia convention.~~

~~(2)~~ Medical literature may be accepted for purposes of division (A) of this section only if all of the following apply:

~~(a)~~(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;

~~(b)~~(2) No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;

~~(c)~~(3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

(C) Coverage of a drug required by division (A) of this section includes medically necessary services associated with the administration of the drug.

(D) Division (A) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States food and drug administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;

(2) Require coverage for experimental drugs not approved for any indication by the United States food and drug administration;

(3) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States food and drug administration;

(4) Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in a policy of sickness and accident insurance;

(5) Prohibit a policy of sickness and accident insurance from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.

(E) This section, as amended, applies only to policies of sickness and accident insurance that are described in division (A) of this section and that are delivered, issued for delivery, or renewed in this state on or after the effective date of this amendment.

Sec. 4731.36. (A) Sections 4731.01 to 4731.47 of the Revised Code shall not prohibit service in case of emergency, domestic administration of family remedies, or provision of assistance to another individual who is self-administering drugs.

Sections 4731.01 to 4731.47 of the Revised Code shall not apply to any of the following:

(1) A commissioned medical officer of the United States armed forces, as defined in section 5903.11 of the Revised Code, or an employee of the veterans administration of the United States or the United States public health service in the discharge of the officer's or employee's professional duties;

(2) A dentist authorized under Chapter 4715. of the Revised Code to practice dentistry when engaged exclusively in the practice of dentistry or when administering anesthetics in the practice of dentistry;

(3) A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein when providing consultation to an individual holding a certificate to practice issued under this chapter who is responsible for the examination, diagnosis, and treatment of the patient who is the subject of the consultation, if one of the following applies:

(a) The physician or surgeon does not provide consultation in this state on a regular or frequent basis.

(b) The physician or surgeon provides the consultation without compensation of any kind, direct or indirect, for the consultation.

(c) The consultation is part of the curriculum of a medical school or osteopathic medical school of this state or a program described in division (A)(2) of section 4731.291 of the Revised Code.

(4) A physician or surgeon in another state or territory who is a legal practitioner of medicine or surgery therein and provided services to a patient in that state or territory, when providing, not later than one year after the last date services were provided in another state or territory, follow-up services in person or through the use of any communication, including oral, written, or electronic communication, in this state to the patient for the same condition;

(5) A physician or surgeon residing on the border of a contiguous state and authorized under the laws thereof to practice medicine and surgery therein, whose practice extends within the limits of this state. Such practitioner shall not either in person or through the use of any communication, including oral, written, or electronic communication, open an office or appoint a place to see patients or receive calls within the limits of this state.

(6) A board, committee, or corporation engaged in the conduct described in division (A) of section 2305.251 of the Revised Code when acting within the scope of the functions of the board, committee, or corporation;

(7) The conduct of an independent review organization accredited by the superintendent of insurance under section ~~3901.80~~ 3922.13 of the Revised Code for the purpose of external reviews conducted under ~~sections 1751.84, 1751.85, 3923.67, 3923.68, 3923.76, and 3923.77~~ Chapter 3922. of the Revised Code.

(B) Sections 4731.51 to 4731.61 of the Revised Code do not apply to any graduate of a podiatric school or college while performing those acts that may be prescribed by or incidental to participation in an accredited podiatric internship, residency, or fellowship program situated in this state approved by the state medical board.

(C) This chapter does not apply to an acupuncturist who complies with Chapter 4762. of the Revised Code.

(D) This chapter does not prohibit the administration of drugs by any of the following:

(1) An individual who is licensed or otherwise specifically authorized by the Revised Code to administer drugs;

(2) An individual who is not licensed or otherwise specifically authorized by the Revised Code to administer drugs, but is acting pursuant to the rules for delegation of medical tasks adopted under section 4731.053 of the Revised Code;

(3) An individual specifically authorized to administer drugs pursuant to a rule adopted under the Revised Code that is in effect on the effective date

of this amendment, as long as the rule remains in effect, specifically authorizing an individual to administer drugs.

(E) The exemptions described in divisions (A)(3), (4), and (5) of this section do not apply to a physician or surgeon whose certificate to practice issued under this chapter is under suspension or has been revoked or permanently revoked by action of the state medical board.

SECTION 2. That existing sections 1751.11, 1751.33, 1751.35, 1751.66, 1751.77, 1751.78, 1751.811, 1751.83, 1751.87, 1751.89, 3901.045, 3923.60, and 4731.36 and sections 1751.831, 1751.84, 1751.85, 1751.88, 3901.80, 3901.81, 3901.82, 3901.83, 3901.84, 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 are hereby repealed.

SECTION 3. This act, other than the amendments to sections 1751.66 and 3923.60 of the Revised Code, shall apply to health benefit plans, as defined in section 3922.01 of the Revised Code as enacted in this act, in effect and under which requests for external review of adverse benefit determinations are submitted on or after January 1, 2012.

_____

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____.

_____

Secretary of State.

File No. _____ Effective Date _____