As Introduced

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Senator Lehner

A B I L L

To amend sections 1751.83, 3922.01, 3922.03, 3922.05, 3922.06, 3922.07, 3922.08, 3922.09, 3922.10, 3922.14, 3922.15, 3922.16, 3922.17, 3922.20, and 4731.36, to enact section 3901.85, and to repeal section 3922.13 of the Revised Code to create the Ohio Health Insurance Oversight Board and to require that external reviews of adverse determinations be conducted by a panel of three clinical peers appointed by the Board.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.83, 3922.01, 3922.03, 3922.05, 3922.06, 3922.07, 3922.08, 3922.09, 3922.10, 3922.14, 3922.15, 3922.16, 3922.17, 3922.20, and 4731.36 be amended and section 3901.85 of the Revised Code be enacted to read as follows:

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 ~~thirty~~ fourteen 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 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 an external review under 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 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 Chapter 3922. 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. 3901.85. (A) There is hereby created within the department of insurance the Ohio health insurance oversight board. The board shall consist of the following members appointed by the superintendent of insurance:

(1) Two consumer representatives;

(2) Two physicians representing insurers;

(3) One podiatrist;

(4) Eleven physicians, who hold a license issued by the state medical board to practice medicine and surgery or osteopathic medicine and surgery, composed as follows:

(a) One general surgeon;

(b) Two surgical physicians;

(c) One family-practice physician;

(d) One psychiatrist;

(e) Two nonsurgical physicians;

(f) One hospital administrator;

(g) One nurse;

(h) One psychologist;

(i) One chiropractor.

(B) The superintendent of insurance shall solicit recommendations for each appointment required under division (A) of this section from the respective trade association of each of the medical fields represented on the board.

(C) The initial members of the board shall serve staggered terms of one, two, or three years, as determined by the superintendent. Thereafter, terms of office for all members shall be three years, with each term ending on the same day of the same month as the term it succeeds. Each member shall hold office from the date of appointment until the end of the term for which the member was appointed. Members may be reappointed.

Vacancies shall be filled in the same manner as original appointments. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of that term. A member shall continue in office subsequent to the expiration date of the member's term until the member's successor takes office or until a period of sixty days has elapsed, whichever occurs first.

(D) The board shall elect a chairperson from one of the physician board members. The board shall meet at the call of the chairperson. A majority of the members of the board constitutes a quorum.

(E) Members of the board shall be reimbursed for all actual necessary expenses incurred while serving on the board.

(F)(1) The board shall provide oversight for health insurance policies and procedures to ensure that those policies and procedures are reasonable and consistent with patient safety.

(2) If the board determines that a policy or procedure of an insurer is not reasonable or consistent with patient safety or that a definition of medical necessity utilized by an administrator is not reasonable or consistent with patient safety, the board shall issue the insurer or administrator a warning and direct the insurer or administrator to remedy the policy, procedure, or definition.

(3) If the insurer or administrator does not remedy the policy, procedure, or definition that the board determined to be unreasonable or inconsistent with patient safety within a reasonable amount of time, the board shall recommend to the superintendent that the superintendent fine the insurer or administrator for noncompliance with the board's directive.

(G) The superintendent may fine an insurer or administrator for noncompliance with the board's directive after a hearing under Chapter 119. of the Revised Code.

(H) Each contract issued by an insurer or administrator shall include a provision that allows the insurer or administrator to amend the terms of the contract as directed by the board.

(I) The board shall annually report to the superintendent of insurance information related to external reviews, as required under section 3922.17 of the Revised Code and shall submit the report to the superintendent of insurance.

(J) As used in this section:

(1) "Insurer" means a health insuring corporation, sickness and accident insurer, multiple employer welfare arrangement, self-insured employer, administrator of a self-insured plan, or public employee benefit plan.

(2) "Administrator" has the same meaning as in section 3959.01 of the Revised Code.

(3) "Trade association" means a statewide or national association that represents professionals in the field of medicine and includes the Ohio state medical association, the Ohio psychological association, the Ohio podiatric medical association, the Ohio hospital association, or the American nurses association. "Trade association" does not mean a labor organization, as defined under section 3517.01 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) "Clinical peer" means a medical provider with expertise in the appropriate medical specialty and who holds a license or certificate in good standing with the relevant state licensing or certifying authority 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 or certificate as the provider who provided the health care services.

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

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

~~(I)~~(J) "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)~~(K) "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)~~(L) "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)~~(M) "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, supplemental coverage, as described in section 3923.37 of the Revised Code, 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)~~(N) "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)~~(O) "Health care provider" or "provider" means a health care professional or facility.

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

~~(P)~~(Q) "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)~~(R) "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 to conduct independent external reviews of adverse benefit determinations 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) "Rescind" means to retroactively cancel or discontinue coverage. "Rescind" does not include canceling or discontinuing coverage that only has a prospective effect or canceling or discontinuing 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. 3922.03. (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 laws or rules or federal regulations.

(B) A health insuring corporation shall consider and provide a written response to each request for a nonexpedited internal review not later than fourteen days after receipt of the request.

(C) 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)~~(D) 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. 3922.05. (A) A health plan issuer shall afford the opportunity for an external review by ~~an independent review organization~~ a panel of three clinical peers appointed by the Ohio health insurance oversight board 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~~ Ohio health insurance oversight board 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, within ten business days after the date of receipt of the notice, submit, in writing, additional information ~~for~~ to either the ~~independent review organization~~ Ohio health insurance oversight board or the superintendent of insurance to consider when conducting the external review.

(2) If the Ohio health insurance oversight board receives additional information under division (D)(1) of this section, the board shall provide this information to the relevant panel of clinical peers;

(3) 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) The Ohio health insurance oversight board shall maintain a randomly organized roster of clinical specialists recommended by the Ohio state medical association or a statewide or national medical specialty board that represents clinical specialists for the purpose of selecting clinical peers to conduct external reviews. The board may, in accordance with Chapter 119. of the Revised Code, adopt rules governing the selection of clinical peers.

(G)(1) If an external review of an adverse benefit determination is granted, the ~~superintendent~~ Ohio health insurance oversight board, according to any rules, policies, or procedures

adopted by the superintendent of insurance shall ~~assign an independent review organization~~ appoint a panel of three clinical peers from the list of ~~organizations~~ clinical peers maintained by the ~~superintendent~~ Ohio health insurance oversight board under division (F) of this section ~~3922.13 of the Revised Code~~ to conduct the external review and shall notify the health plan issuer of the ~~name~~ names of the ~~assigned independent review organization~~ appointed clinical peers.

(2) The ~~assignment~~ appointment of ~~an approved independent review organization~~ a panel of clinical peers shall be done on a random basis from those ~~independent review organizations~~ clinical peers 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~~ Ohio health insurance oversight board shall not ~~choose an independent review organization~~ appoint a clinical peer with a conflict of interest, as prescribed under section 3922.14 of the Revised Code.

~~(G)~~(H) 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~~ appointed panel of clinical peers 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~~ panel 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)~~(I)(1) ~~An independent review organization assigned~~ A panel of clinical peers appointed 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 by the health plan issuer of a request for a standard

review or a standard review involving an experimental or investigational treatment, or within seventy-two hours of receipt by the health plan issuer 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;

(d) The Ohio health insurance oversight board.

(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~~ panel of clinical peers was ~~assigned~~ appointed by the ~~superintendent of insurance~~ Ohio health insurance oversight board 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~~ panel of clinical peers' 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)~~(J) Upon receipt of a notice by ~~an independent review organization~~ a panel of clinical peers to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.

(K) If an adverse benefit determination is overturned under

this chapter, the superintendent of insurance shall levy against the health plan issuer in question a fine equal to three times the cost of the medical care provided under division (J) of this section. Any such fees collected under this section shall be paid into the state treasury and credited to the department of insurance operating fund created by section 3901.021 of the Revised Code.

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~~ the Ohio health insurance oversight board 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)~~(J) 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 based upon 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~~ appointed panel of clinical peers, the Ohio health insurance oversight board, and the superintendent of insurance.

Upon receipt of such a notification, the ~~assigned independent review organization~~ panel of clinical peers 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~~ appointed panel of clinical peers, 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~~ panel of clinical peers' 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~~ appointed panel of clinical peers 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~~ A panel of clinical peers 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~~ panel of clinical peers 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~~ panel of clinical peers shall notify, within one business day of making the decision, the covered person, the health plan issuer, ~~and~~ the superintendent of insurance, and the Ohio health insurance oversight board.

Sec. 3922.09. (A) A covered person may make a request for an expedited external review, except as provided in division (I) 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, or would jeopardize the covered person's ability to regain

maximum function, if treated after the time frame of an expedited internal appeal;

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

(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 (A) 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~~ panel of clinical peers appointed by the Ohio health insurance oversight board

electronically, or by facsimile or other available expeditious method.

(D) In addition to the information transmitted under division (C) of this section, the ~~assigned independent review organization~~ appointed panel of clinical peers 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 receipt by the health plan issuer of a request for an expedited, external review, the ~~assigned independent review organization~~ appointed panel of clinical peers 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 (C) of this section, the ~~independent review organization~~ panel of clinical peers shall not delay the external review and may accordingly reverse the adverse benefit determination.

(G) ~~An independent review organization~~ The appointed panel of clinical peers shall promptly notify the covered person, health plan issuer, ~~and~~ the superintendent of insurance, and the Ohio health insurance oversight board of any decision made under this section. If such a notice is not made in writing, the ~~independent review organization~~ panel of clinical peers, shall provide, within forty-eight hours of making the decision, written confirmation, including the information required under division ~~(H)~~(I)(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, and the Ohio health insurance oversight board.

(H) Upon receipt of a notice by ~~an independent review organization~~ a panel of clinical peers 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 service covered by the health plan issuer that is more beneficial than the 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 (C)(1) 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~~ appointed panel of clinical peers 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 a standard external review;

(2) For an expedited external review, immediately electronically, or by 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~~ a panel of clinical peers under this section, the ~~assigned independent review organization~~ Ohio health insurance oversight board shall select physicians or other health care professionals who meet the minimum qualifications described in section 3922.15 of the Revised Code.

~~(G)~~(F) Neither the covered person, nor the health plan

issuer, shall choose or have any influence over the choice of the clinical ~~reviewer or reviewers~~ peers chosen ~~under division (E) of this section~~ by the Ohio health insurance oversight board.

~~(H)~~(G)(1) Each chosen clinical ~~reviewer~~ peer shall provide a written opinion to the ~~assigned independent review organization~~ Ohio health insurance oversight board on whether the adverse benefit determination should be upheld or reversed.

(2) In reaching such opinions, a clinical ~~reviewer~~ peer 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 ~~(K)~~(J)(2)(b) or (c) of this section.

~~(I)~~(H) 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)~~(I)(1) ~~An independent review organization~~ A panel of clinical peers may reverse an adverse benefit determination, if the information required under division (D) of this section is not provided in the allotted time. The ~~independent review organization~~ panel of clinical peers 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)~~(I)(1) of this section, the ~~independent review organization~~ panel of clinical peers shall immediately notify the covered person, the health plan issuer, the Ohio health insurance oversight board, and the superintendent of insurance.

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

~~(M)~~(L)(1) Within thirty days after the date of receipt by the health plan issuer of a request for a standard external review, or within seventy-two hours of receipt by the health plan issuer of a request for an expedited external review, the ~~assigned independent review organization~~ appointed panel of clinical peers shall provide written notice of its decision to uphold or reverse the adverse benefit determination to the covered person, the health plan issuer, the Ohio health insurance oversight board, and the superintendent of insurance.

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

(b) If a majority of the clinical ~~reviewers~~ peers recommend that the recommended or requested health care service or treatment should not be covered, the ~~independent review organization~~ panel of clinical peers 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~~ panel of clinical peers shall include in the notice provided pursuant to division ~~(M)~~(L)(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~~ peer, including the recommendation of each clinical ~~reviewer~~ peer 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~~ panel of clinical peers was ~~assigned~~ appointed by the ~~superintendent~~ Ohio health insurance oversight board 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)~~(M) Upon receipt of a notice of a decision by an ~~independent review organization~~ panel of clinical peers pursuant to division ~~(M)~~(L)(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. 3922.14. (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~~ A clinical peer may not own or control~~, be a subsidiary of or in any way be owned or controlled by, or exercise control with~~ a health plan issuer, a national, state, or local trade association of health plan issuers, or a national, state, or local trade association of health care providers.

~~(C)~~(B)(1) ~~Neither the independent review organization selected to conduct the external review nor any~~ No clinical ~~reviewer assigned~~ peer appointed by the ~~independent organization~~ Ohio health insurance oversight board 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~~ peer has a material professional, familial, or financial conflict of interest for purposes of division ~~(C)~~(B)(1) of this section. In making this determination, the superintendent may take into consideration situations where ~~an independent review organization, or~~ a clinical ~~reviewer~~ peer, 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~~ constitute an actual 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~~ peer 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~~ (C) A panel of clinical peers 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~~ peers appointed by ~~an independent review organization~~ the Ohio health insurance oversight board 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, and, in the case of an external review of an experimental or investigational health care service, be an expert, through

clinical experience in the last three years, in the treatment of the covered person's condition and have knowledge of the requested health care service;

(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 or independent review organization~~ peer 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 clinical reviewer an independent review organization uses in conducting an external review under this chapter~~ A clinical peer 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 or clinical reviewer~~ a 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~~ The Ohio health insurance oversight board 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~~ The Ohio health insurance oversight board shall annually 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~~ panels of

clinical peers to conduct the reviews;

(g) The medical specialty, or the type, of clinical ~~reviewer~~ peers 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~~ Ohio health insurance oversight board 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. 3922.20. Consistent with the Rules of Evidence, a written decision or opinion prepared by ~~an independent review organization~~ a panel of clinical peers 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~~ panel of clinical peers' 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. 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 3922.13 of the Revised Code for the purpose of external reviews conducted under 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~~ April 10, 2001, 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 1751.83, 3922.01, 3922.03, 3922.05, 3922.06, 3922.07, 3922.08, 3922.09, 3922.10, 3922.14, 3922.15, 3922.16, 3922.17, 3922.20, and 4731.36 and section 3922.13 of the Revised Code are hereby repealed.