Ohio External Claim Review Information Packet

Please read this packet carefully. This packet contains important information about how to request an External Claim Review in the State of Ohio.

I. External Review

A. External Review Process

1. Preliminary Determination by Superintendent

A request for review of a denied health care service may be made to the Superintendent of Insurance of the State of Ohio. On receipt of such request from you or your representative, the Superintendent will consider whether the health care service is covered under the terms of your policy or certificate. The Superintendent will not conduct a review unless you have exhausted all administrative rights of appeal under your health insurance coverage. The insurer and you or your representative will provide the Superintendent with any information required for the review.

The Superintendent will notify you and your insurer of its determination or that it is not able to make a determination because resolution of a medical issue is required.

If the Superintendent notifies the insurer that making the determination requires the resolution of a medical issue, the insurer will give you an opportunity for External Review. If the Superintendent notifies the insurer that the health care service is not a covered service, the insurer is not required to cover the service nor afford you an External Review.

2. Review Procedures

You will have an opportunity for an External Review of a coverage denial if both of the following are the case:

- Your insurer has denied, reduced, or terminated coverage for what would be a covered service except that your insurer has determined the service is not medically necessary.
- Except in the case of Expedited External Review (See I.C.), the proposed service, plus any ancillary services and follow-up care, will cost you more than five hundred dollars if the proposed service is not covered by your insurer.

If you have a terminal condition and meet all of the criteria in I.D. External Review of Denial of Experimental or Investigational Treatment for Terminal Illness, an External Review will be conducted under that section.

You will not be afforded an External Review in any of the following circumstances:

- The Superintendent of Insurance has determined that the health care service is not a service covered under the terms of your policy or certificate.
- You have failed to exhaust all administrative rights of appeal under your health insurance coverage.
- You have previously had an External Review for the same denial of coverage, and no new clinical information has been submitted to your insurer.
- You request an External Review later than sixty (60) days after your receipt of notice from the Superintendent of Insurance that making a determination requires the resolution of a medical issue.

An External Review may be requested by you, your representative, your provider, or a health care facility rendering health care service to you. You may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without your prior consent.

An External Review must be requested in writing, except that if you have a condition that requires Expedited Review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted by you to your insurer not later than five days after the request is made.

Except in the case of an Expedited External Review, a request for an External Review must be accompanied by written certification from your provider or the health care facility rendering the health care service that the proposed service, plus any ancillary services and follow-up care, will cost you more than five hundred dollars ($500) if the proposed service is not covered by your insurer.

You must send your request for External Review in writing to:

Name:	Allied National, Inc.
Address:	Attn. Claim Review
	PO Box 29186
	Shawnee Mission, KS 66201-9186
Phone:	800-825-7531
FAX:	913-945-4399

The procedures used in conducting an External Review will include all of the following:

- The review will be conducted by an Independent Review Organization (IRO) assigned by the Superintendent of Insurance. The review will be requested by your insurer.
- Except as provided below, neither a clinical peer nor any health care facility with which the clinical peer is affiliated will have any professional, familial, or financial affiliation with any of the following:

  (i) your insurer or any officer, director, or managerial employee of your insurer;
  (ii) you, your provider, or the practice group of your provider;
  (iii) the health care facility at which the health care service requested by you would be provided;
  (iv) the development or manufacture of the principal drug, device, procedure, or therapy proposed for you.
- A clinical peer may conduct a review under any of the following circumstances:

  (i) the clinical peer is affiliated with an academic medical center that provides health care services to insureds of the insurer;
  (ii) the clinical peer has staff privileges at a health care facility that provides health care services to insureds of the insurer;
  (iii) the clinical peer has a contractual relationship with the insurer but was not involved with the insurer's coverage decision.
- The cost of the review will be paid by your insurer.

Your insurer will provide to the Independent Review Organization a copy of those records in its possession that are relevant to your medical condition and the review.

Your insurer, you, your provider, or health care facility will provide any additional information the Independent Review Organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. If such request is submitted orally or by electronic means, not later than five days after the request is submitted, the Independent Review Organization will provide written confirmation of the request. If the review was initiated by a provider or health care facility, a copy of the request will be submitted to the provider or health care facility.

3. Independent Review Organization Decision

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

The insurer may elect to cover the service requested and terminate the review. The insurer will notify you and all other parties involved with such a decision by mail, or with your consent and approval, by electronic means.

In making its decision, an Independent Review Organization conducting the review will take into account all of the following:

- Information submitted by the insurer, you, your provider, and the health care facility rendering the health care service, including the following:

  (i) your medical records;
  (ii) the standards, criteria, and clinical rationale used by the insurer to make its decision.

- Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, the United States Food and Drug Administration, the Health Care Financing Administration of the United States Department of Health and Human Services, and the Agency for Health Care Policy and Research.

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

B. Decision

A written decision will be issued not later than thirty days after the filing of the request. The Independent Review Organization will send a copy of its decision to you and your insurer. If your provider or health care facility requested the review, the Independent Review Organization will also send a copy of its decision to them.

The Independent Review Organization's decision will include a description of your condition, the principal reasons for the decision, and an explanation of the clinical rationale for the decision.

The Independent Review Organization will base its decision on the information submitted. In making its decision, the Independent Review Organization will consider safety, efficacy, appropriateness, and cost-effectiveness.

The insurer will provide any coverage determined by the Independent Review Organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of your policy or certificate.

C. Expedited External Review

If you have an emergency medical condition, your provider must certify that your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing your health or, with respect to a pregnant woman, your health or the unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

The Independent Review Organization will issue a written decision not later than seven days after the filing of the request of review.

D. External Review of Denial of Experimental or Investigative Treatment for Terminal Conditions

If you have a terminal condition for which your insurer has denied coverage, you will be notified within 30 business days after denial of coverage, of your right to an External Review. Your condition must meet all of the following criteria to be eligible for review:

- You have a terminal condition that, according to the current diagnosis of your physician, has a high probability of causing death within two years.
- You request a review not later than sixty (60) days after receipt of notice from the Superintendent of Insurance that making a determination requires resolution of a medical issue.
- Your physician certifies that you have a terminal condition and any of the following situations are applicable:

  (i) standard therapies have not been effective in improving your condition;
  (ii) standard therapies are not medically appropriate;
  (iii) there is no standard therapy covered by your insurer that is more beneficial than therapy described in the next paragraph.

- Your physician has recommended a drug, device, procedure, or other therapy that certified, in writing, is likely to be more beneficial than standard therapies, or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
- You have been denied coverage by your insurer for a drug, device, procedure, or other therapy and have exhausted your insurer's internal review process.
- The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for your insurer's determination that it is experimental or investigational.

A review must be requested in writing, except that if your physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request will be submitted to your insurer not later than five days after such a request is submitted.

The review will be conducted by an Independent Review Organization assigned by the Superintendent of Insurance.

The Independent Review Organization will select a panel to conduct the review. The panel will be composed of at least three physicians or other providers who, through clinical experience in the past three years, are experts in the treatment of your medical condition and knowledgeable about the recommended or requested therapy.

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

- A review may be conducted by an expert panel composed of only two physicians or other providers if you have consented in writing to a review by the smaller panel.
- A review may be conducted by a single expert physician or other provider if only the expert physician or other provider is available for the review.

Neither you nor your insurer will choose, or control the choice of, the physician or other provider experts.

The selected experts, any health care facility with which an expert is affiliated, and the Independent Review Organization arranging for the experts' review will not have any professional, familial, or financial affiliation with any of the following:

- your insurer or any officer, director, or managerial employee of your insurer;
- you, your physician, or the practice group of the physician;
- the health care facility at which the recommended or requested therapy would be provided;
- the development or manufacture of the principal drug, device, procedure, or therapy involved in the recommended or requested therapy.

Experts affiliated with academic medical centers who provide health care services to insureds of your insurer may serve as experts on the review panel. Further, experts with staff privileges at a health care facility that provides health care services to insureds of your insurer, as well as experts who have a contractual relationship with your insurer, but who were not involved with the insurer's denial of coverage for the therapy under review, may serve as experts on the review panel. These nonaffiliation provisions do not preclude an insurer from paying for the experts' review.

The cost of the review will be paid by your insurer.

Your insurer will provide a copy of those records in the insurer's possession that are relevant to your medical condition and the review to the Independent Review Organization arranging for the experts' review. The records will be disclosed solely to the expert reviewers. At the request of the expert reviewers, your insurer or the physician requesting the therapy will provide any additional information that the expert reviewers request to complete the review. An expert reviewer is not required to render an opinion if the reviewer has not received any requested information that the reviewer considers necessary to complete the review.

In the case of an Expedited Review, the Independent Review Organization will issue a written decision not later than seven days after the filing of the request for review. In all other cases, the Independent Review Organization will issue a written decision not later than thirty days after the filing of the request. The Independent Review Organization will send

a copy of its decision to you and your insurer. If your provider or the health care facility requested the review, the Independent Review Organization will also send a copy of its decision to them.

In conducting the review, the experts on the panel will take into account all of the following:

- information submitted by your insurer, you, and your physician, including your medical records and the standards, criteria, and clinical rationale used by your insurer to reach its coverage decision;
- findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations;
- relevant findings in peer-reviewed medical or scientific literature and published opinions of nationally recognized medical experts;
- clinical guidelines adopted by relevant national medical societies;
- safety, efficacy, appropriateness, and cost effectiveness.

Each expert on the panel will provide the Independent Review Organization with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely to be more beneficial to you than standard therapies.

Each expert's opinion will be presented in written form and include the following information:

- a description of your condition;
- 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 you than standard therapies;
- a description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;
- a description of your suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

The Independent Review Organization will provide your insurer with the opinions of the experts. Your insurer will make the experts' opinions available to you and your physician, upon request.

The opinion of the majority of the experts on the panel is binding on your insurer. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, your insurer's final decision will be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, your insurer may, in its discretion, cover the therapy. However, any coverage provided is subject to the terms, limitations, and conditions of your policy or certificate.

If your insurer's initial denial of coverage is based upon an External Review of that therapy meeting the requirements of this section I.D., then this section I.D. will not be a basis for requiring a second External Review of the recommended therapy.

At any time during the External Review process, your insurer may elect to cover the recommended or requested health care service and terminate the review. Your insurer will notify you and all other parties involved by mail or, with your consent or approval, by electronic means.

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation

If you decide to request an external review, you must give the person who will be responsible for processing the review any material justification or documentation for the review at the time the review is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. “Properly addressed” means your last known address.