**As Reported by the Senate Insurance Committee**

**131st General Assembly**
**Regular Session**
**2015-2016**

**Sub. S. B. No. 129**

**Senators Gardner, Cafaro**

**Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares**

# A BILL

To amend section 1739.05 and to enact sections 1751.72, 3923.041, and 5160.34 of the Revised Code to amend the law related to the prior authorization requirements of insurers.

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

**Section 1.** That section 1739.05 be amended and sections 1751.72, 3923.041, and 5160.34 of the Revised Code be enacted to read as follows:

**Sec. 1739.05.** (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment

of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

(E) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code is subject to, and shall comply with, sections 3903.81 to 3903.93 of the Revised Code in the same manner as other life or health insurers, as defined in section 3903.81 of the Revised Code.

**Sec. 1751.72.** (A) As used in this section:

(1) "Chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

(2) "Clinical peer" means a health care practitioner in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

(3) "Covered person" means a person receiving coverage for health services under a policy, contract, or agreement issued by a health insuring corporation.

(4) "Emergency medical service" and "trauma care" have the same meanings as in section 4765.01 of the Revised Code.

(5) "Fraudulent or materially incorrect information" means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the covered person in question.

(6) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(7) "NCPDP SCRIPT standard" means the national council for prescription drug programs SCRIPT standard version 201310 or the most recent standard adopted by the the United States department of health and human services.

(8) "Prior authorization requirement" means any practice implemented by a health insuring corporation in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the health insuring corporation prior to the service,

device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(9) "Utilization review" and "utilization review organization" have the same meanings as in section 1751.77 of the Revised Code.

(B) If a policy, contract, or agreement issued by a health insuring corporation contains a prior authorization requirement, then all of the following apply:

(1) On or before January 1, 2018, the health insuring corporation shall permit health care practitioners to access the prior authorization form through the applicable electronic software system.

(2)(a) On or before January 1, 2018, the health insuring corporation or other payer acting on behalf of the health insuring corporation, shall accept prior authorization requests through a secure electronic transmission.

(b) On or before January 1, 2018, the health insuring corporation, a pharmacy benefit manager responsible for handling prior authorization requests, or other payer acting on behalf of the health insuring corporation shall accept and respond to prior prescription benefit authorization requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions, and for prior medical benefit authorization requests through a secure electronic transmission using standards established by the council for affordable quality health care on operating rules for information exchange or its successor.

(c) For purposes of division (B)(2) of this section, neither of the following shall be considered a secure electronic transmission:

(i) A facsimile;

(ii) A proprietary payer portal that does not use NCPDP SCRIPT standard.

(3) On or before January 1, 2018, a health care practitioner and health insuring corporation may enter into a contractual arrangement under which the health insuring corporation agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the health care practitioner or if internet connectivity is limited or unavailable where the health care practitioner is located.

(4)(a) On or before January 1, 2018, if the health care practitioner submits the request for prior authorization as described in division (B)(1), (2), or (3) of this section, the health insuring corporation shall respond to all prior authorization requests within one business day for urgent care services, or five business days for any prior approval request that is not for an urgent care service, of the time the request is received by the health insuring corporation with all information necessary to support the prior authorization request. Division (B)(4) of this section does not apply to emergency medical services or trauma care.

(b)(i) The response required under division (B)(4)(a) of this section shall indicate whether the request is approved, denied, or incomplete. If the prior authorization is denied, the

health insuring corporation shall provide the specific reason for the denial. If the prior authorization request is incomplete, the health insuring corporation shall indicate the specific additional information that is required to process the request.

(ii) For a response that is considered incomplete, after all information requested by a health insuring corporation has been provided by the health care practitioner, the health insuring corporation shall respond to the prior approval request in accordance with the deadlines prescribed in division (B)(4)(a) of this section.

(5) On or before January 1, 2018, if a health care practitioner submits a prior authorization request as described in division (B)(1), (2), or (3) of this section, the health insuring corporation shall provide a written receipt to the health care practitioner acknowledging that the prior authorization request was received.

(6)(a) On or before January 1, 2017, for a prior approval related to a chronic condition, the health insuring corporation shall honor a prior authorization approval for an approved drug for the lesser of the following from the date of the approval:

(i) Twelve months;

(ii) The last day of the covered person's eligibility under the policy, contract, or agreement.

(b) The duration of all other prior authorization approvals shall be dictated by the policy, contract, or agreement issued by the health insuring corporation.

(c) A health insuring corporation may, in relation to a prior approval under division (B)(6)(a) of this section, require

a health care practitioner to submit information to the health insuring corporation indicating that the patient's chronic condition has not changed. The health insuring corporation may require this information no earlier than six months, but no later than seven months, after the initial prior approval request was submitted.

(d) A year long approval provided under division (B)(6)(a) of this section is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose.

(7) On or before January 1, 2017, a health insuring corporation may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that meets all of the following:

(a) The drug is prescribed for an individual with a complex or rare medical condition.

(b) The drug costs six hundred dollars or more for up to a thirty-day supply.

(c) The drug is not typically stocked at retail pharmacies.

(d) The drug has at least one of the following characteristics:

(i) It requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug.

(ii) It requires enhanced patient education, management,

or support, beyond those required for traditional dispensing, before or after administration of the drug.

(8) On or before January 1, 2017, a health insuring corporation may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that has a typical treatment plan of less than one year.

(9)(a) On or after January 1, 2017, upon written request, a health insuring corporation shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required but not obtained if the service in question meets all of the following:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the time the original authorized service was performed.

(b) Once the written request and all necessary information is received, the health insuring corporation shall review the claim for coverage and medical necessity. The health insuring corporation shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

(10)(a) On or before January 1, 2017, the health insuring corporation shall disclose to all participating health care practitioners any new prior authorization requirement at least thirty days prior to the effective date of the new requirement.

(b) The notice may be sent via electronic mail or standard mail and shall be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but shall include specific information on where the health care practitioner may locate the information on the health insuring corporation's web site or, if applicable, the health insuring corporation's portal.

(11)(a) On or before January 1, 2017, the health insuring corporation shall make available to all participating health care practitioners on its web site or provider portal a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

(b) The health insuring corporation shall make available on its web site information about the policies, contracts, or agreements offered by the health insuring corporation that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(12) On or before January 1, 2018, the health insuring corporation shall establish a streamlined reconsideration and appeal process relating to adverse prior authorization decision determinations that shall include all of the following:

(a) For urgent care services, the reconsideration shall occur within one business day after the health insuring corporation receives the request for reconsideration. For any prior approval request that is not for an urgent care service, the reconsideration shall occur within two business days after the health insuring corporation receives the request for

reconsideration.

(b) The reconsideration shall be conducted between the health care practitioner and the reviewer who made the adverse determination. If the reviewer cannot be available in accordance with division (B)(12)(a) of this section, the reviewer shall designate another reviewer. If the health care practitioner cannot be available in accordance with division (B)(12)(a) of this section, the health care practitioner may designate another health care practitioner.

(c) If the reconsideration does not resolve the disagreement, the health care practitioner may appeal the adverse determination.

(d) For urgent care services, the appeal shall be heard within one business day after the health insuring corporation receives the appeal. For all other matters, the appeal shall be heard within five business days after the health insuring corporation receives the appeal.

(e) The appeal shall be between the health care practitioner requesting the service in question and a clinical peer.

(f) If the appeal does not resolve the disagreement, either the health care practitioner or the covered person may request an external review under Chapter 3922. of the Revised Code.

(C)(1) Beginning January 1, 2017, except in cases of fraudulent or materially incorrect information, prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the health insuring corporation if obtained not more than sixty days prior to the

date the service, drug, or device is provided or received.

(2) A health insuring corporation shall not be required to cover a service, drug, or device in accordance with division (C)(1) of this section if, due to the covered individual switching health plans, the service, drug, or device is no longer considered a covered service, drug, or device at the time the service, drug, or device is provided.

(D) Beginning January 1, 2017, a health insuring corporation may not impose a restriction or condition in relation to prior authorization determinations that limits, restricts, or effectively eliminates the binding force of these determinations that is established under this section.

(E) Beginning January 1, 2017, committing a series of violations of this section that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice under sections 3901.19 to 3901.26 of the Revised Code.

**Sec. 3923.041.** (A) As used in this section:

(1) "Chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

(2) "Clinical peer" means a health care practitioner in the same or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

(3) "Covered person" means a person receiving coverage for health services under a policy of sickness and accident insurance or a public employee benefit plan.

(4) "Emergency medical service" and "trauma care" have the

same meanings as in section 4765.01 of the Revised Code.

(5) "Fraudulent or materially incorrect information" means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the covered person in question.

(6) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(7) "NCPDP SCRIPT standard" means the national council for prescription drug programs SCRIPT standard version 201310 or the most recent standard adopted by the the United States department of health and human services.

(8) "Prior authorization requirement" means any practice implemented by either a sickness and accident insurer or a public employee benefit plan in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the insurer or plan prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(9) "Urgent care services" has the same meaning as under section 1751.01 of the Revised Code.

(10) "Utilization review" and "utilization review organization" have the same meanings as in section 1751.77 of the Revised Code.

(B) If a policy issued by a sickness and accident insurer or a public employee benefit plan contains a prior authorization requirement, then all of the following apply:

(1) On or before January 1, 2018, the insurer or plan shall permit health care practitioners to access the prior authorization form through the applicable electronic software system.

(2)(a) On or before January 1, 2018, the insurer or plan, or other payer acting on behalf of the insurer or plan, to accept prior authorization requests through a secure electronic transmission.

(b) On or before January 1, 2018, the insurer or plan, a pharmacy benefit manager responsible for handling prior authorization requests, or other payer acting on behalf of the insurer or plan shall accept and respond to prior prescription benefit authorization requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions, and for prior medical benefit authorization requests through a secure electronic transmission using standards established by the council for affordable quality health care on operating rules for information exchange or its successor.

(c) For purposes of division (B)(2) of this section, neither of the following shall be considered a secure electronic transmission:

(i) A facsimile;

(ii) A proprietary payer portal that does not use NCPDP SCRIPT standard.

(3) On or before January 1, 2018, a health care practitioner and an insurer or plan may enter into a contractual arrangement under which the insurer or plan agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic

submission of prior authorization requests would create for the health care practitioner or if internet connectivity is limited or unavailable where the health care practitioner is located.

(4)(a) On or before January 1, 2018, if the health care practitioner submits the request for prior authorization electronically as described in division (B)(1), (2), or (3) of this section, the insurer or plan shall respond to all prior authorization requests within one business day for urgent care services, or five business days for prior approval request that is not for an urgent care service, of the time the request is received by the insurer or plan with all information necessary to support the prior authorization request. Division (B)(4) of this section does not apply to emergency medical services or trauma care.

(b)(i) The response required under division (B)(4)(a) of this section shall indicate whether the request is approved, denied, or incomplete. If the prior authorization is denied, the insurer or plan shall provide the specific reason for the denial. If the prior authorization request is incomplete, the insurer or plan shall indicate the specific additional information that is required to process the request.

(ii) For a response that is considered incomplete, after all information requested by an insurer or plan has been provided by the health care practitioner, the insurer or plan shall respond to the prior approval request in accordance with the deadlines prescribed in division (B)(4)(a) of this section.

(5) On or before January 1, 2018, if a health care practitioner submits a prior authorization request as described in division (B)(1), (2), or (3) of this section, the insurer or plan shall provide a written receipt to the health care

practitioner acknowledging that the prior authorization request was received.

(6)(a) On or before January 1, 2017, for a prior approval related to a chronic condition, the insurer or plan shall honor a prior authorization approval for an approved drug for the lesser of the following from the date of the approval:

(i) Twelve months;

(ii) The last day of the covered person's eligibility under the policy or plan.

(b) The duration of all other prior authorization approvals shall be dictated by the policy or plan.

(c) An insurer or plan, in relation to prior approval under division (B)(6)(a) of this section, may require a health care practitioner to submit information to the insurer or plan indicating that the patient's chronic condition has not changed. The insurer or plan may require this information not earlier than six months, but not later than seven months, after the initial prior approval request was submitted.

(d) A year long approval provided under division (B)(6)(a) of this section is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose.

(7) On or before January 1, 2017, an insurer or plan may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that meets all of the following:

(a) The drug is prescribed for an individual with a complex or rare medical condition.

(b) The drug costs six hundred dollars or more for up to a thirty-day supply.

(c) The drug is not typically stocked at retail pharmacies.

(d) The drug has at least one of the following characteristics:

(i) It requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug.

(ii) It requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

(8) On or before January 1, 2017, an insurer or plan may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that has a typical treatment plan of less than one year.

(9)(a) On or after January 1, 2017, upon written request, an insurer or plan shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required but not obtained if the service in question meets all of the following:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the

time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the time the original authorized service was performed.

(b) Once the written request and all necessary information is received, the insurer or plan shall review the claim for coverage and medical necessity. The insurer or plan shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

(10)(a) On or before January 1, 2017, the insurer or plan shall disclose to all participating health care practitioners any new prior authorization requirement at least thirty days prior to the effective date of the new requirement.

(b) The notice may be sent via electronic mail or standard mail and shall be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but shall include specific information on where the health care practitioner may locate the information on the insurer or plan's web site or, if applicable, the insurer's or plan's portal.

(11)(a) On or before January 1, 2017, the insurer or plan shall make available to all participating health care practitioners on its web site or provider portal a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

(b) The insurer or plan shall make available on its web

site information about the policies, contracts, or agreements offered by the insurer or plan that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(12) On or before January 1, 2018, the insurer or plan shall establish a streamlined reconsideration and appeal process relating to adverse prior authorization determinations that shall include all of the following:

(a) For urgent care services, the reconsideration shall occur within one business day after the insurer or plan receives the request for reconsideration. For any prior approval request that is not for an urgent care service, the reconsideration shall occur within two business days after the insurer or plan receives the request for reconsideration.

(b) The reconsideration shall be conducted between the health care practitioner and the reviewer who made the adverse determination. If the reviewer cannot be available as prescribed in division (B)(12)(a) of this section, the reviewer shall designate another reviewer. If the health care practitioner cannot be available in accordance with division (B)(12)(a) of this section, the health care practitioner may designate another health care practitioner.

(c) If the reconsideration does not resolve the disagreement, the health care practitioner may appeal the adverse determination.

(d) For urgent care services, the appeal shall be heard within one business day after the insurer or plan receives the appeal. For all other matters, the appeal shall be heard within five business days after the insurer or plan receives the

appeal.

(e) The appeal shall be between the health care practitioner requesting the service in question and a clinical peer.

(f) If the appeal does not resolve the disagreement, either the health care practitioner or the covered person may request an external review under Chapter 3922. of the Revised Code.

(C)(1) Beginning January 1, 2017, except in cases of fraudulent or materially incorrect information, prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer or plan if obtained not more than sixty days prior to the date the service, drug, or device is provided or received.

(2) An insurer or plan shall not be required to cover a service, drug, or device in accordance with division (C)(1) of this section if, due to the covered individual switching health plans, the service, drug, or device is no longer considered a covered service, drug, or device at the time the service, drug, or device is provided.

(D) Beginning January 1, 2017, an insurer or plan shall not impose a restriction or condition in relation to prior authorization determinations that limits, restricts, or effectively eliminates the binding force of these determinations that is established under this section.

(E) Beginning January 1, 2017, committing a series of violations of this section that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice under sections 3901.19 to 3901.26 of the Revised Code.

**Sec. 5160.34.** (A) As used in this section:

(1) "Chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

(2) "Clinical peer" means a medical provider in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

(3) "Emergency medical service" and "trauma care" have the same meanings as in section 4765.01 of the Revised Code.

(4) "Prior authorization requirement" means any practice implemented by a medical assistance program in which coverage of a health care service, device, or drug is dependent upon a medical assistance recipient or a health care provider, receiving approval from the department of medicaid or its designee, including a medicaid managed care organization, prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(5) "Urgent care services" has the same meaning as in section 1751.01 of the Revised Code.

(6) "Utilization review" and "utilization review organization" have the same meanings as in section 1751.77 of the Revised Code.

(B) If a medical assistance program has a prior authorization requirement, the department of medicaid or its designee, including a medicaid managed care organization, shall do all of the following:

(1) On or before January 1, 2018, permit a health care provider to access the prior authorization form through the applicable electronic software system.

(2)(a) On or before January 1, 2018, permit the department or its designee to accept and respond to prior prescription benefit authorization requests through a secure electronic transmission.

(b) On or before January 1, 2018, the department or its designee shall accept and respond to prior prescription benefit authorization requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions, and for prior medical benefit authorization requests through a secure electronic transmission using standards established by the council for affordable quality health care on operating rules for information exchange or its successor.

(c) For purposes of division (B)(2) of this section, neither of the following shall be considered a secure electronic transmission:

(i) A facsimile;

(ii) A proprietary payer portal that does not use NCPDP SCRIPT standard.

(3) On or before January 1, 2018, a health care provider and the department of medicaid or its designee may enter into a contractual arrangement under which the department or its designee agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the provider or if internet connectivity is limited or unavailable where the provider is located.

(4)(a) On or before January 1, 2018, if the health care provider submits the request for prior authorization electronically as described in division (B)(1), (2), or (3) of this section, respond to all prior authorization requests within one business day for urgent care services, or five business days for any prior approval request that is not for an urgent care service, of the time the request is received by the department or its designee with all information necessary to support the prior authorization request. Division (B)(5) of this section does not apply to emergency medical services or trauma care.

(b)(i) The response required under division (B)(4)(a) of this section shall indicate whether the request was approved, denied, or is incomplete. If the prior authorization is denied, the department or its designee shall provide the specific reason for the denial. If the prior authorization request is incomplete, the department or its designee shall indicate the specific additional information that is required to process the request.

(ii) For a response that is considered incomplete, after all information requested by the department or its designee has been provided by the health care practitioner, the department or its designee shall respond to the prior approval request in accordance with the deadlines prescribed in division (B)(4)(a) of this section.

(5) On or before January 1, 2018, if a health care provider submits a prior authorization request as described in division (B)(1), (2), or (3) of this section, the department or its designee shall provide a written receipt to the health care provider acknowledging that the prior authorization request was received.

(6)(a) On or before January 1, 2017, honor a prior authorization approval for an approved drug for the lesser of the following from the date of approval:

(i) Twelve months;

(ii) The last day of the medical assistance recipient's eligibility for the medical assistance program.

(b) The duration of all other prior authorization approvals shall be dictated by the medical assistance program.

(c) The department or its designee, in relation to prior approval under division (B)(6)(a) of this section, may require a health care provider to submit information to the department or its designee indicating that the patient's chronic condition has not changed. The department or its designee may require this information not earlier than six months, but not later than seven months, after the initial prior approval request was submitted.

(d) A year long approval provided under division (B)(6)(a) of this section is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose.

(7) On or before January 1, 2017, the department or its designee may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that meets all of the following:

(a) The drug is prescribed for an individual with a complex or rare medical condition.

(b) The drug costs six hundred dollars or more for up to a thirty-day supply.

(c) The drug is not typically stocked at retail pharmacies.

(d) The drug has at least one of the following characteristics:

(i) It requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug.

(ii) It requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

(8) On or before January 1, 2017, the department or its designee may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that has a typical treatment plan of less than one year.

(9)(a) On or after January 1, 2017, upon written request, the department or its designee shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required, but not obtained if the service in question meets all of the following:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the

time the original authorized service was performed.

(b) Once the written request and all necessary information is received, the department or its designee shall review the claim for coverage and medical necessity. The department or its designee shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

(10)(a) On or before January 1, 2017, disclose to all participating health care providers any new prior authorization requirement at least thirty days prior to the effective date of the new requirement.

(b) The notice may be sent via electronic mail or standard mail and shall be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but shall include specific information on where the health care practitioner may locate the information on the department's or its designee's web site or, if applicable, the department's or its designee's portal.

(11)(a) On or before January 1, 2017, make available to all participating health care providers on its web site or provider portal a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

(b) Make available on its web site information about the medical assistance programs offered in this state that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists.

(12) On or before January 1, 2018, establish a streamlined reconsideration and appeal process relating to adverse prior authorization determinations that shall include all of the following:

(a) For urgent care services, the reconsideration shall occur within one business day after the department or its designee receives the request for reconsideration. For any prior approval request that is not for an urgent care service, the reconsideration shall occur within two business days after the department or its designee receives the request for reconsideration.

(b) The reconsideration shall be conducted between the medical provider and the reviewer who made the adverse determination. If the reviewer cannot be available as prescribed in division (B)(12)(a) of this section, the reviewer shall designate another reviewer. If the health care practitioner cannot be available in accordance with division (B)(12)(a) of this section, the health care practitioner may designate another health care practitioner.

(c) If the reconsideration does not resolve the disagreement, the health care provider may appeal the adverse determination.

(d) For urgent care services, the appeal shall be heard within one business day after the department or its designee receives the appeal. For all other matters, the appeal shall be heard within five business days after the department or its designee receives the appeal.

(e) The appeal shall be between the health care provider requesting the service in question and a clinical peer.

(f) If the appeal does not resolve the disagreement, either the health care provider or the covered person request an external review under section 5101.35 of the Revised Code.

(C)(1) Beginning January 1, 2017, except in cases of fraudulent or materially incorrect information, prior determinations relation to benefit coverage and medical necessity shall be binding on the department or its designee if obtained not more than sixty days prior to the date the service, drug, or device is provided or received.

(2) The department or its designee shall not be required to cover a service, drug, or device in accordance with division (C)(1) of this section if, due to the covered individual switching health plans, the service, drug, or device is no longer considered a covered service, drug, or device at the time the service, drug, or device is provided.

(D) Beginning January 1, 2017, a department or its designee shall not impose a restriction or condition in relation to prior authorization determinations that limits, restricts, or effectively eliminates the binding force of these determinations that is established under this section.

**Section 2.** That existing section 1739.05 of the Revised Code is hereby repealed.