

As Passed by the Senate

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Sub. S. B. No. 129

Senators Gardner, Cafaro

**Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite,
Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer,
Schiavoni, Thomas, Uecker**

A BILL

To amend section 1739.05 and to enact sections 1
1751.72, 3923.041, and 5160.34 of the Revised 2
Code to amend the law related to the prior 3
authorization requirements of insurers. 4

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

Section 1. That section 1739.05 be amended and sections 5
1751.72, 3923.041, and 5160.34 of the Revised Code be enacted to 6
read as follows: 7

Sec. 1739.05. (A) A multiple employer welfare arrangement 8
that is created pursuant to sections 1739.01 to 1739.22 of the 9
Revised Code and that operates a group self-insurance program 10
may be established only if any of the following applies: 11

(1) The arrangement has and maintains a minimum enrollment 12
of three hundred employees of two or more employers. 13

(2) The arrangement has and maintains a minimum enrollment 14
of three hundred self-employed individuals. 15

(3) The arrangement has and maintains a minimum enrollment 16

of three hundred employees or self-employed individuals in any 17
combination of divisions (A) (1) and (2) of this section. 18

(B) A multiple employer welfare arrangement that is 19
created pursuant to sections 1739.01 to 1739.22 of the Revised 20
Code and that operates a group self-insurance program shall 21
comply with all laws applicable to self-funded programs in this 22
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 23
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 24
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 25
3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 26
3924.031, 3924.032, and 3924.27 of the Revised Code. 27

(C) A multiple employer welfare arrangement created 28
pursuant to sections 1739.01 to 1739.22 of the Revised Code 29
shall solicit enrollments only through agents or solicitors 30
licensed pursuant to Chapter 3905. of the Revised Code to sell 31
or solicit sickness and accident insurance. 32

(D) A multiple employer welfare arrangement created 33
pursuant to sections 1739.01 to 1739.22 of the Revised Code 34
shall provide benefits only to individuals who are members, 35
employees of members, or the dependents of members or employees, 36
or are eligible for continuation of coverage under section 37
1751.53 or 3923.38 of the Revised Code or under Title X of the 38
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 39
Stat. 227, 29 U.S.C.A. 1161, as amended. 40

(E) A multiple employer welfare arrangement created 41
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 42
subject to, and shall comply with, sections 3903.81 to 3903.93 43
of the Revised Code in the same manner as other life or health 44
insurers, as defined in section 3903.81 of the Revised Code. 45

Sec. 1751.72. (A) As used in this section: 46

(1) "Chronic condition" means a medical condition that has 47
persisted after reasonable efforts have been made to relieve or 48
cure its cause and has continued, either continuously or 49
episodically, for longer than six continuous months. 50

(2) "Clinical peer" means a health care practitioner in 51
the same, or in a similar, specialty that typically manages the 52
medical condition, procedure, or treatment under review. 53

(3) "Covered person" means a person receiving coverage for 54
health services under a policy, contract, or agreement issued by 55
a health insuring corporation. 56

(4) "Emergency medical service" and "trauma care" have the 57
same meanings as in section 4765.01 of the Revised Code. 58

(5) "Fraudulent or materially incorrect information" means 59
any type of intentional deception or misrepresentation made by a 60
person with the knowledge that the deception could result in 61
some unauthorized benefit to the covered person in question. 62

(6) "Health care practitioner" has the same meaning as in 63
section 3701.74 of the Revised Code. 64

(7) "NCPDP SCRIPT standard" means the national council for 65
prescription drug programs SCRIPT standard version 201310 or the 66
most recent standard adopted by the the United States department 67
of health and human services. 68

(8) "Prior authorization requirement" means any practice 69
implemented by a health insuring corporation in which coverage 70
of a health care service, device, or drug is dependent upon a 71
covered person or a health care practitioner obtaining approval 72
from the health insuring corporation prior to the service, 73

device, or drug being performed, received, or prescribed, as 74
applicable. "Prior authorization" includes prospective or 75
utilization review procedures conducted prior to providing a 76
health care service, device, or drug. 77

(9) "Utilization review" and "utilization review 78
organization" have the same meanings as in section 1751.77 of 79
the Revised Code. 80

(B) If a policy, contract, or agreement issued by a health 81
insuring corporation contains a prior authorization requirement, 82
then all of the following apply: 83

(1) On or before January 1, 2018, the health insuring 84
corporation shall permit health care practitioners to access the 85
prior authorization form through the applicable electronic 86
software system. 87

(2) (a) On or before January 1, 2018, the health insuring 88
corporation or other payer acting on behalf of the health 89
insuring corporation, shall accept prior authorization requests 90
through a secure electronic transmission. 91

(b) On or before January 1, 2018, the health insuring 92
corporation, a pharmacy benefit manager responsible for handling 93
prior authorization requests, or other payer acting on behalf of 94
the health insuring corporation shall accept and respond to 95
prior prescription benefit authorization requests through a 96
secure electronic transmission using NCPDP SCRIPT standard ePA 97
transactions, and for prior medical benefit authorization 98
requests through a secure electronic transmission using 99
standards established by the council for affordable quality 100
health care on operating rules for information exchange or its 101
successor. 102

(c) For purposes of division (B) (2) of this section, 103
neither of the following shall be considered a secure electronic 104
transmission: 105

(i) A facsimile; 106

(ii) A proprietary payer portal that does not use NCPDP 107
SCRIPT standard. 108

(3) On or before January 1, 2018, a health care 109
practitioner and health insuring corporation may enter into a 110
contractual arrangement under which the health insuring 111
corporation agrees to process prior authorization requests that 112
are not submitted electronically because of the financial 113
hardship that electronic submission of prior authorization 114
requests would create for the health care practitioner or if 115
internet connectivity is limited or unavailable where the health 116
care practitioner is located. 117

(4) (a) On or before January 1, 2018, if the health care 118
practitioner submits the request for prior authorization as 119
described in division (B) (1), (2), or (3) of this section, the 120
health insuring corporation shall respond to all prior 121
authorization requests within one business day for urgent care 122
services, or five business days for any prior approval request 123
that is not for an urgent care service, of the time the request 124
is received by the health insuring corporation with all 125
information necessary to support the prior authorization 126
request. Division (B) (4) of this section does not apply to 127
emergency medical services or trauma care. 128

(b) (i) The response required under division (B) (4) (a) of 129
this section shall indicate whether the request is approved, 130
denied, or incomplete. If the prior authorization is denied, the 131

health insuring corporation shall provide the specific reason 132
for the denial. If the prior authorization request is 133
incomplete, the health insuring corporation shall indicate the 134
specific additional information that is required to process the 135
request. 136

(ii) For a response that is considered incomplete, after 137
all information requested by a health insuring corporation has 138
been provided by the health care practitioner, the health 139
insuring corporation shall respond to the prior approval request 140
in accordance with the deadlines prescribed in division (B) (4) 141
(a) of this section. 142

(5) On or before January 1, 2018, if a health care 143
practitioner submits a prior authorization request as described 144
in division (B) (1), (2), or (3) of this section, the health 145
insuring corporation shall provide a written receipt to the 146
health care practitioner acknowledging that the prior 147
authorization request was received. 148

(6) (a) On or before January 1, 2017, for a prior approval 149
related to a chronic condition, the health insuring corporation 150
shall honor a prior authorization approval for an approved drug 151
for the lesser of the following from the date of the approval: 152

(i) Twelve months; 153

(ii) The last day of the covered person's eligibility 154
under the policy, contract, or agreement. 155

(b) The duration of all other prior authorization 156
approvals shall be dictated by the policy, contract, or 157
agreement issued by the health insuring corporation. 158

(c) A health insuring corporation may, in relation to a 159
prior approval under division (B) (6) (a) of this section, require 160

a health care practitioner to submit information to the health 161
insuring corporation indicating that the patient's chronic 162
condition has not changed. The health insuring corporation may 163
require this information no earlier than six months, but no 164
later than seven months, after the initial prior approval 165
request was submitted. 166

(d) A year long approval provided under division (B) (6) (a) 167
of this section is no longer valid and automatically terminates 168
if there are changes to federal or state laws or federal 169
regulatory guidance or compliance information prescribing that 170
the drug in question is no longer approved or safe for the 171
intended purpose. 172

(7) On or before January 1, 2017, a health insuring 173
corporation may, but is not required to, provide the twelve- 174
month approval prescribed in division (B) (6) (a) of this section 175
for a prescription drug that meets all of the following: 176

(a) The drug is prescribed for an individual with a 177
complex or rare medical condition. 178

(b) The drug costs six hundred dollars or more for up to a 179
thirty-day supply. 180

(c) The drug is not typically stocked at retail 181
pharmacies. 182

(d) The drug has at least one of the following 183
characteristics: 184

(i) It requires a difficult or unusual process of delivery 185
to the patient in the preparation, handling, storage, inventory, 186
or distribution of the drug. 187

(ii) It requires enhanced patient education, management, 188

or support, beyond those required for traditional dispensing, 189
before or after administration of the drug. 190

(8) On or before January 1, 2017, a health insuring 191
corporation may, but is not required to, provide the twelve- 192
month approval prescribed in division (B)(6)(a) of this section 193
for a prescription drug that has a typical treatment plan of 194
less than one year. 195

(9)(a) On or after January 1, 2017, upon written request, 196
a health insuring corporation shall permit a retrospective 197
review for a claim that is submitted for a service where prior 198
authorization was required but not obtained if the service in 199
question meets all of the following: 200

(i) The service is directly related to another service for 201
which prior approval has already been obtained and that has 202
already been performed. 203

(ii) The new service was not known to be needed at the 204
time the original prior authorized service was performed. 205

(iii) The need for the new service was revealed at the 206
time the original authorized service was performed. 207

(b) Once the written request and all necessary information 208
is received, the health insuring corporation shall review the 209
claim for coverage and medical necessity. The health insuring 210
corporation shall not deny a claim for such a new service based 211
solely on the fact that a prior authorization approval was not 212
received for the new service in question. 213

(10)(a) On or before January 1, 2017, the health insuring 214
corporation shall disclose to all participating health care 215
practitioners any new prior authorization requirement at least 216
thirty days prior to the effective date of the new requirement. 217

(b) The notice may be sent via electronic mail or standard 218
mail and shall be conspicuously entitled "Notice of Changes to 219
Prior Authorization Requirements." The notice is not required to 220
contain a complete listing of all changes made to the prior 221
authorization requirements, but shall include specific 222
information on where the health care practitioner may locate the 223
information on the health insuring corporation's web site or, if 224
applicable, the health insuring corporation's portal. 225

(11) (a) On or before January 1, 2017, the health insuring 226
corporation shall make available to all participating health 227
care practitioners on its web site or provider portal a listing 228
of its prior authorization requirements, including specific 229
information or documentation that a provider must submit in 230
order for the prior authorization request to be considered 231
complete. 232

(b) The health insuring corporation shall make available 233
on its web site information about the policies, contracts, or 234
agreements offered by the health insuring corporation that 235
clearly identifies specific services, drugs, or devices to which 236
a prior authorization requirement exists. 237

(12) On or before January 1, 2018, the health insuring 238
corporation shall establish a streamlined reconsideration and 239
appeal process relating to adverse prior authorization decision 240
determinations that shall include all of the following: 241

(a) For urgent care services, the reconsideration shall 242
occur within one business day after the health insuring 243
corporation receives the request for reconsideration. For any 244
prior approval request that is not for an urgent care service, 245
the reconsideration shall occur within two business days after 246
the health insuring corporation receives the request for 247

reconsideration. 248

(b) The reconsideration shall be conducted between the 249
health care practitioner and the reviewer who made the adverse 250
determination. If the reviewer cannot be available in accordance 251
with division (B)(12)(a) of this section, the reviewer shall 252
designate another reviewer. If the health care practitioner 253
cannot be available in accordance with division (B)(12)(a) of 254
this section, the health care practitioner may designate another 255
health care practitioner. 256

(c) If the reconsideration does not resolve the 257
disagreement, the health care practitioner may appeal the 258
adverse determination. 259

(d) For urgent care services, the appeal shall be heard 260
within one business day after the health insuring corporation 261
receives the appeal. For all other matters, the appeal shall be 262
heard within five business days after the health insuring 263
corporation receives the appeal. 264

(e) The appeal shall be between the health care 265
practitioner requesting the service in question and a clinical 266
peer. 267

(f) If the appeal does not resolve the disagreement, 268
either the health care practitioner or the covered person may 269
request an external review under Chapter 3922. of the Revised 270
Code. 271

(C)(1) Beginning January 1, 2017, except in cases of 272
fraudulent or materially incorrect information, prior 273
authorization determinations relating to benefit coverage and 274
medical necessity shall be binding on the health insuring 275
corporation if obtained not more than sixty days prior to the 276

date the service, drug, or device is provided or received. 277

(2) A health insuring corporation shall not be required to 278
cover a service, drug, or device in accordance with division (C) 279
(1) of this section if, due to the covered individual switching 280
health plans, the service, drug, or device is no longer 281
considered a covered service, drug, or device at the time the 282
service, drug, or device is provided. 283

(D) Beginning January 1, 2017, a health insuring 284
corporation may not impose a restriction or condition in 285
relation to prior authorization determinations that limits, 286
restricts, or effectively eliminates the binding force of these 287
determinations that is established under this section. 288

(E) Beginning January 1, 2017, committing a series of 289
violations of this section that, taken together, constitute a 290
practice or pattern shall be considered an unfair and deceptive 291
practice under sections 3901.19 to 3901.26 of the Revised Code. 292

Sec. 3923.041. (A) As used in this section: 293

(1) "Chronic condition" means a medical condition that has 294
persisted after reasonable efforts have been made to relieve or 295
cure its cause and has continued, either continuously or 296
episodically, for longer than six continuous months. 297

(2) "Clinical peer" means a health care practitioner in 298
the same or in a similar, specialty that typically manages the 299
medical condition, procedure, or treatment under review. 300

(3) "Covered person" means a person receiving coverage for 301
health services under a policy of sickness and accident 302
insurance or a public employee benefit plan. 303

(4) "Emergency medical service" and "trauma care" have the 304

same meanings as in section 4765.01 of the Revised Code. 305

(5) "Fraudulent or materially incorrect information" means 306
any type of intentional deception or misrepresentation made by a 307
person with the knowledge that the deception could result in 308
some unauthorized benefit to the covered person in question. 309

(6) "Health care practitioner" has the same meaning as in 310
section 3701.74 of the Revised Code. 311

(7) "NCPDP SCRIPT standard" means the national council for 312
prescription drug programs SCRIPT standard version 201310 or the 313
most recent standard adopted by the the United States department 314
of health and human services. 315

(8) "Prior authorization requirement" means any practice 316
implemented by either a sickness and accident insurer or a 317
public employee benefit plan in which coverage of a health care 318
service, device, or drug is dependent upon a covered person or a 319
health care practitioner obtaining approval from the insurer or 320
plan prior to the service, device, or drug being performed, 321
received, or prescribed, as applicable. "Prior authorization" 322
includes prospective or utilization review procedures conducted 323
prior to providing a health care service, device, or drug. 324

(9) "Urgent care services" has the same meaning as under 325
section 1751.01 of the Revised Code. 326

(10) "Utilization review" and "utilization review 327
organization" have the same meanings as in section 1751.77 of 328
the Revised Code. 329

(B) If a policy issued by a sickness and accident insurer 330
or a public employee benefit plan contains a prior authorization 331
requirement, then all of the following apply: 332

(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. 333
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(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. 337
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(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. 341
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(c) For purposes of division (B) (2) of this section, neither of the following shall be considered a secure electronic transmission: 351
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(i) A facsimile; 354

(ii) A proprietary payer portal that does not use NCPDP SCRIPT standard. 355
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(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 357
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submission of prior authorization requests would create for the 362
health care practitioner or if internet connectivity is limited 363
or unavailable where the health care practitioner is located. 364

(4) (a) On or before January 1, 2018, if the health care 365
practitioner submits the request for prior authorization 366
electronically as described in division (B) (1), (2), or (3) of 367
this section, the insurer or plan shall respond to all prior 368
authorization requests within one business day for urgent care 369
services, or five business days for prior approval request that 370
is not for an urgent care service, of the time the request is 371
received by the insurer or plan with all information necessary 372
to support the prior authorization request. Division (B) (4) of 373
this section does not apply to emergency medical services or 374
trauma care. 375

(b) (i) The response required under division (B) (4) (a) of 376
this section shall indicate whether the request is approved, 377
denied, or incomplete. If the prior authorization is denied, the 378
insurer or plan shall provide the specific reason for the 379
denial. If the prior authorization request is incomplete, the 380
insurer or plan shall indicate the specific additional 381
information that is required to process the request. 382

(ii) For a response that is considered incomplete, after 383
all information requested by an insurer or plan has been 384
provided by the health care practitioner, the insurer or plan 385
shall respond to the prior approval request in accordance with 386
the deadlines prescribed in division (B) (4) (a) of this section. 387

(5) On or before January 1, 2018, if a health care 388
practitioner submits a prior authorization request as described 389
in division (B) (1), (2), or (3) of this section, the insurer or 390
plan shall provide a written receipt to the health care 391

practitioner acknowledging that the prior authorization request 392
was received. 393

(6) (a) On or before January 1, 2017, for a prior approval 394
related to a chronic condition, the insurer or plan shall honor 395
a prior authorization approval for an approved drug for the 396
lesser of the following from the date of the approval: 397

(i) Twelve months; 398

(ii) The last day of the covered person's eligibility 399
under the policy or plan. 400

(b) The duration of all other prior authorization 401
approvals shall be dictated by the policy or plan. 402

(c) An insurer or plan, in relation to prior approval 403
under division (B) (6) (a) of this section, may require a health 404
care practitioner to submit information to the insurer or plan 405
indicating that the patient's chronic condition has not changed. 406
The insurer or plan may require this information not earlier 407
than six months, but not later than seven months, after the 408
initial prior approval request was submitted. 409

(d) A year long approval provided under division (B) (6) (a) 410
of this section is no longer valid and automatically terminates 411
if there are changes to federal or state laws or federal 412
regulatory guidance or compliance information prescribing that 413
the drug in question is no longer approved or safe for the 414
intended purpose. 415

(7) On or before January 1, 2017, an insurer or plan may, 416
but is not required to, provide the twelve-month approval 417
prescribed in division (B) (6) (a) of this section for a 418
prescription drug that meets all of the following: 419

(a) The drug is prescribed for an individual with a 420
complex or rare medical condition. 421

(b) The drug costs six hundred dollars or more for up to a 422
thirty-day supply. 423

(c) The drug is not typically stocked at retail 424
pharmacies. 425

(d) The drug has at least one of the following 426
characteristics: 427

(i) It requires a difficult or unusual process of delivery 428
to the patient in the preparation, handling, storage, inventory, 429
or distribution of the drug. 430

(ii) It requires enhanced patient education, management, 431
or support, beyond those required for traditional dispensing, 432
before or after administration of the drug. 433

(8) On or before January 1, 2017, an insurer or plan may, 434
but is not required to, provide the twelve-month approval 435
prescribed in division (B) (6) (a) of this section for a 436
prescription drug that has a typical treatment plan of less than 437
one year. 438

(9) (a) On or after January 1, 2017, upon written request, 439
an insurer or plan shall permit a retrospective review for a 440
claim that is submitted for a service where prior authorization 441
was required but not obtained if the service in question meets 442
all of the following: 443

(i) The service is directly related to another service for 444
which prior approval has already been obtained and that has 445
already been performed. 446

(ii) The new service was not known to be needed at the 447

time the original prior authorized service was performed. 448

(iii) The need for the new service was revealed at the 449
time the original authorized service was performed. 450

(b) Once the written request and all necessary information 451
is received, the insurer or plan shall review the claim for 452
coverage and medical necessity. The insurer or plan shall not 453
deny a claim for such a new service based solely on the fact 454
that a prior authorization approval was not received for the new 455
service in question. 456

(10) (a) On or before January 1, 2017, the insurer or plan 457
shall disclose to all participating health care practitioners 458
any new prior authorization requirement at least thirty days 459
prior to the effective date of the new requirement. 460

(b) The notice may be sent via electronic mail or standard 461
mail and shall be conspicuously entitled "Notice of Changes to 462
Prior Authorization Requirements." The notice is not required to 463
contain a complete listing of all changes made to the prior 464
authorization requirements, but shall include specific 465
information on where the health care practitioner may locate the 466
information on the insurer or plan's web site or, if applicable, 467
the insurer's or plan's portal. 468

(11) (a) On or before January 1, 2017, the insurer or plan 469
shall make available to all participating health care 470
practitioners on its web site or provider portal a listing of 471
its prior authorization requirements, including specific 472
information or documentation that a provider must submit in 473
order for the prior authorization request to be considered 474
complete. 475

(b) The insurer or plan shall make available on its web 476

site information about the policies, contracts, or agreements 477
offered by the insurer or plan that clearly identifies specific 478
services, drugs, or devices to which a prior authorization 479
requirement exists. 480

(12) On or before January 1, 2018, the insurer or plan 481
shall establish a streamlined reconsideration and appeal process 482
relating to adverse prior authorization determinations that 483
shall include all of the following: 484

(a) For urgent care services, the reconsideration shall 485
occur within one business day after the insurer or plan receives 486
the request for reconsideration. For any prior approval request 487
that is not for an urgent care service, the reconsideration 488
shall occur within two business days after the insurer or plan 489
receives the request for reconsideration. 490

(b) The reconsideration shall be conducted between the 491
health care practitioner and the reviewer who made the adverse 492
determination. If the reviewer cannot be available as prescribed 493
in division (B) (12) (a) of this section, the reviewer shall 494
designate another reviewer. If the health care practitioner 495
cannot be available in accordance with division (B) (12) (a) of 496
this section, the health care practitioner may designate another 497
health care practitioner. 498

(c) If the reconsideration does not resolve the 499
disagreement, the health care practitioner may appeal the 500
adverse determination. 501

(d) For urgent care services, the appeal shall be heard 502
within one business day after the insurer or plan receives the 503
appeal. For all other matters, the appeal shall be heard within 504
five business days after the insurer or plan receives the 505

appeal. 506

(e) The appeal shall be between the health care practitioner requesting the service in question and a clinical peer. 507
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(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. 510
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(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. 514
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(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. 520
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(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. 526
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(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. 531
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Sec. 5160.34. (A) As used in this section: 535

(1) "Chronic condition" means a medical condition that has 536
persisted after reasonable efforts have been made to relieve or 537
cure its cause and has continued, either continuously or 538
episodically, for longer than six continuous months. 539

(2) "Clinical peer" means a medical provider in the same, 540
or in a similar, specialty that typically manages the medical 541
condition, procedure, or treatment under review. 542

(3) "Emergency medical service" and "trauma care" have the 543
same meanings as in section 4765.01 of the Revised Code. 544

(4) "Prior authorization requirement" means any practice 545
implemented by a medical assistance program in which coverage of 546
a health care service, device, or drug is dependent upon a 547
medical assistance recipient or a health care provider, 548
receiving approval from the department of medicaid or its 549
designee, including a medicaid managed care organization, prior 550
to the service, device, or drug being performed, received, or 551
prescribed, as applicable. "Prior authorization" includes 552
prospective or utilization review procedures conducted prior to 553
providing a health care service, device, or drug. 554

(5) "Urgent care services" has the same meaning as in 555
section 1751.01 of the Revised Code. 556

(6) "Utilization review" and "utilization review 557
organization" have the same meanings as in section 1751.77 of 558
the Revised Code. 559

(B) If a medical assistance program has a prior 560
authorization requirement, the department of medicaid or its 561
designee, including a medicaid managed care organization, shall 562
do all of the following: 563

(1) On or before January 1, 2018, permit a health care provider to access the prior authorization form through the applicable electronic software system. 564
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(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. 567
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(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. 571
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(c) For purposes of division (B) (2) of this section, neither of the following shall be considered a secure electronic transmission: 579
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(i) A facsimile; 582

(ii) A proprietary payer portal that does not use NCPDP SCRIPT standard. 583
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(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. 585
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(4) (a) On or before January 1, 2018, if the health care 593
provider submits the request for prior authorization 594
electronically as described in division (B) (1), (2), or (3) of 595
this section, respond to all prior authorization requests within 596
one business day for urgent care services, or five business days 597
for any prior approval request that is not for an urgent care 598
service, of the time the request is received by the department 599
or its designee with all information necessary to support the 600
prior authorization request. Division (B) (5) of this section 601
does not apply to emergency medical services or trauma care. 602

(b) (i) The response required under division (B) (4) (a) of 603
this section shall indicate whether the request was approved, 604
denied, or is incomplete. If the prior authorization is denied, 605
the department or its designee shall provide the specific reason 606
for the denial. If the prior authorization request is 607
incomplete, the department or its designee shall indicate the 608
specific additional information that is required to process the 609
request. 610

(ii) For a response that is considered incomplete, after 611
all information requested by the department or its designee has 612
been provided by the health care practitioner, the department or 613
its designee shall respond to the prior approval request in 614
accordance with the deadlines prescribed in division (B) (4) (a) 615
of this section. 616

(5) On or before January 1, 2018, if a health care 617
provider submits a prior authorization request as described in 618
division (B) (1), (2), or (3) of this section, the department or 619
its designee shall provide a written receipt to the health care 620
provider acknowledging that the prior authorization request was 621
received. 622

(6) (a) On or before January 1, 2017, honor a prior 623
authorization approval for an approved drug for the lesser of 624
the following from the date of approval: 625

(i) Twelve months; 626

(ii) The last day of the medical assistance recipient's 627
eligibility for the medical assistance program. 628

(b) The duration of all other prior authorization 629
approvals shall be dictated by the medical assistance program. 630

(c) The department or its designee, in relation to prior 631
approval under division (B) (6) (a) of this section, may require a 632
health care provider to submit information to the department or 633
its designee indicating that the patient's chronic condition has 634
not changed. The department or its designee may require this 635
information not earlier than six months, but not later than 636
seven months, after the initial prior approval request was 637
submitted. 638

(d) A year long approval provided under division (B) (6) (a) 639
of this section is no longer valid and automatically terminates 640
if there are changes to federal or state laws or federal 641
regulatory guidance or compliance information prescribing that 642
the drug in question is no longer approved or safe for the 643
intended purpose. 644

(7) On or before January 1, 2017, the department or its 645
designee may, but is not required to, provide the twelve-month 646
approval prescribed in division (B) (6) (a) of this section for a 647
prescription drug that meets all of the following: 648

(a) The drug is prescribed for an individual with a 649
complex or rare medical condition. 650

(b) The drug costs six hundred dollars or more for up to a 651
thirty-day supply. 652

(c) The drug is not typically stocked at retail 653
pharmacies. 654

(d) The drug has at least one of the following 655
characteristics: 656

(i) It requires a difficult or unusual process of delivery 657
to the patient in the preparation, handling, storage, inventory, 658
or distribution of the drug. 659

(ii) It requires enhanced patient education, management, 660
or support, beyond those required for traditional dispensing, 661
before or after administration of the drug. 662

(8) On or before January 1, 2017, the department or its 663
designee may, but is not required to, provide the twelve-month 664
approval prescribed in division (B) (6) (a) of this section for a 665
prescription drug that has a typical treatment plan of less than 666
one year. 667

(9) (a) On or after January 1, 2017, upon written request, 668
the department or its designee shall permit a retrospective 669
review for a claim that is submitted for a service where prior 670
authorization was required, but not obtained if the service in 671
question meets all of the following: 672

(i) The service is directly related to another service for 673
which prior approval has already been obtained and that has 674
already been performed. 675

(ii) The new service was not known to be needed at the 676
time the original prior authorized service was performed. 677

(iii) The need for the new service was revealed at the 678

time the original authorized service was performed. 679

(b) Once the written request and all necessary information 680
is received, the department or its designee shall review the 681
claim for coverage and medical necessity. The department or its 682
designee shall not deny a claim for such a new service based 683
solely on the fact that a prior authorization approval was not 684
received for the new service in question. 685

(10) (a) On or before January 1, 2017, disclose to all 686
participating health care providers any new prior authorization 687
requirement at least thirty days prior to the effective date of 688
the new requirement. 689

(b) The notice may be sent via electronic mail or standard 690
mail and shall be conspicuously entitled "Notice of Changes to 691
Prior Authorization Requirements." The notice is not required to 692
contain a complete listing of all changes made to the prior 693
authorization requirements, but shall include specific 694
information on where the health care practitioner may locate the 695
information on the department's or its designee's web site or, 696
if applicable, the department's or its designee's portal. 697

(11) (a) On or before January 1, 2017, make available to 698
all participating health care providers on its web site or 699
provider portal a listing of its prior authorization 700
requirements, including specific information or documentation 701
that a provider must submit in order for the prior authorization 702
request to be considered complete. 703

(b) Make available on its web site information about the 704
medical assistance programs offered in this state that clearly 705
identifies specific services, drugs, or devices to which a prior 706
authorization requirement exists. 707

(12) On or before January 1, 2018, establish a streamlined 708
reconsideration and appeal process relating to adverse prior 709
authorization determinations that shall include all of the 710
following: 711

(a) For urgent care services, the reconsideration shall 712
occur within one business day after the department or its 713
designee receives the request for reconsideration. For any prior 714
approval request that is not for an urgent care service, the 715
reconsideration shall occur within two business days after the 716
department or its designee receives the request for 717
reconsideration. 718

(b) The reconsideration shall be conducted between the 719
medical provider and the reviewer who made the adverse 720
determination. If the reviewer cannot be available as prescribed 721
in division (B) (12) (a) of this section, the reviewer shall 722
designate another reviewer. If the health care practitioner 723
cannot be available in accordance with division (B) (12) (a) of 724
this section, the health care practitioner may designate another 725
health care practitioner. 726

(c) If the reconsideration does not resolve the 727
disagreement, the health care provider may appeal the adverse 728
determination. 729

(d) For urgent care services, the appeal shall be heard 730
within one business day after the department or its designee 731
receives the appeal. For all other matters, the appeal shall be 732
heard within five business days after the department or its 733
designee receives the appeal. 734

(e) The appeal shall be between the health care provider 735
requesting the service in question and a clinical peer. 736

(f) If the appeal does not resolve the disagreement, 737
either the health care provider or the covered person request an 738
external review under section 5101.35 of the Revised Code. 739

(C) (1) Beginning January 1, 2017, except in cases of 740
fraudulent or materially incorrect information, prior 741
determinations relation to benefit coverage and medical 742
necessity shall be binding on the department or its designee if 743
obtained not more than sixty days prior to the date the service, 744
drug, or device is provided or received. 745

(2) The department or its designee shall not be required 746
to cover a service, drug, or device in accordance with division 747
(C) (1) of this section if, due to the covered individual 748
switching health plans, the service, drug, or device is no 749
longer considered a covered service, drug, or device at the time 750
the service, drug, or device is provided. 751

(D) Beginning January 1, 2017, a department or its 752
designee shall not impose a restriction or condition in relation 753
to prior authorization determinations that limits, restricts, or 754
effectively eliminates the binding force of these determinations 755
that is established under this section. 756

Section 2. That existing section 1739.05 of the Revised 757
Code is hereby repealed. 758