

I_135_0725-2

135th General Assembly
Regular Session
2023-2024

Sub. H. B. No. 130

A BILL

To amend section 5160.34 and to enact sections 1
1751.721, 1751.722, 1751.723, 3923.042, 2
3923.043, 3923.044, 5160.341, and 5160.342 of 3
the Revised Code to establish an exemption to 4
prior authorization requirements. 5

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

Section 1. That section 5160.34 be amended and sections 6
1751.721, 1751.722, 1751.723, 3923.042, 3923.043, 3923.044, 7
5160.341, and 5160.342 of the Revised Code be enacted to read as 8
follows: 9

Sec. 1751.721. (A) A health insuring corporation that 10
applies a prior authorization requirement shall do both of the 11
following: 12

(1) Make prior authorization data available on its public 13
web site in a readily accessible format and update the data not 14
later than the first day of April annually; 15

(2) Submit prior authorization data to the superintendent 16
of insurance not later than the first day of April annually. 17



vtwat59lztwoo8rlz2a4ij

(B) The data shall include all of the following 18
information: 19

(1) The specialty of the health care provider requesting 20
the prior authorization; 21

(2) Whether the prior authorization is for a health care 22
service, a medical device, or a drug; 23

(3) The indication for use of the service, device, or drug 24
under the prior authorization; 25

(4) If the prior authorization request was denied, the 26
reason for the denial; 27

(5) If the approval or denial of a prior authorization 28
request was appealed and the result of the appeal; 29

(6) The amount of time between the submission of a prior 30
authorization request and the response from the corporation. 31

Sec. 1751.722. (A) (1) If a health insuring corporation has 32
a prior authorization requirement for a health care service or 33
medical device, the corporation shall not require a health care 34
provider or health care provider group to comply with the 35
requirement for that health care service or device if both of 36
the following criteria are met: 37

(a) The corporation approved or would have approved at 38
least ninety-five per cent of the prior authorization requests 39
submitted by the health care provider or health care provider 40
group for that service or device during the previous twelve- 41
month period. 42

(b) The health care provider or health care provider group 43
submitted at least twenty prior authorization requests for that 44
service or device to the corporation during that twelve-month 45

period. 46

(2) Such an exemption shall be provided for not less than 47
twelve months. 48

(3) An exemption under division (A) of this section shall 49
not be granted regarding a prior authorization requirement for a 50
drug. 51

(4) Nothing in this section shall be construed as 52
prohibiting a corporation from establishing an exemption period 53
of more than twelve months. 54

(B) (1) A health care provider or health care provider 55
group that does not receive an exemption under division (A) of 56
this section may request that the corporation provide evidence 57
to the provider or provider group supporting its decision to not 58
grant an exemption. 59

(2) The health care provider or health care provider group 60
may make such a request at any time, but it may make not more 61
than one such request for the same service or device in a 62
calendar year. 63

(3) A health insuring corporation shall comply with such a 64
request. 65

(C) A health care provider or health care provider group 66
may appeal a health insuring corporation's decision to deny an 67
exemption. 68

(D) A health insuring corporation shall not do either of 69
the following: 70

(1) Require a health care provider or health care provider 71
group to request an exemption provided under division (A) of 72
this section; 73

(2) Deny or reduce payment for a health care service or 74
medical device that was provided without prior authorization 75
pursuant to an exemption granted under division (A) of this 76
section on the sole basis that the service or device was 77
provided by or supervised by a health care provider or health 78
care provider group that is different than the provider or 79
provider group that requested the exemption. This division does 80
not apply if the providing or supervising provider or provider 81
group does either of the following: 82

(a) Knowingly and materially misrepresents the health care 83
service or medical device provided in its request for payment 84
from the health insuring corporation with the intent to obtain 85
an unlawful payment amount from the health insuring corporation; 86

(b) Fails to substantially perform the health care service 87
or to provide the medical device. 88

(E) When an exemption is granted under division (A) of 89
this section for a health care service or medical device, the 90
corporation shall notify the health care provider or health care 91
provider group in question. The notice shall be in writing and 92
include all of the following information: 93

(1) A statement that the health care provider or health 94
care provider group qualifies for an exemption to a prior 95
authorization requirement; 96

(2) The health care service or medical device to which the 97
exemption applies; 98

(3) The dates the exemption will begin and end. 99

(F) (1) At the end of the exemption period, a health 100
insuring corporation may evaluate an exemption it has granted 101
under division (A) of this section. 102

(2) (a) A corporation conducting such an evaluation shall 103
review twenty claims submitted to the corporation, selected at 104
random, for the health care service or medical device in 105
question. 106

(b) The reviewed claims shall be from the immediately 107
preceding three months. If there are not twenty relevant claims 108
in the preceding three months, the corporation may review 109
earlier claims. 110

(3) (a) If less than ninety-five per cent of the reviewed 111
claims would have been approved based on medical necessity, then 112
the corporation may revoke the exemption provided under division 113
(A) of this section. 114

(b) A corporation that is revoking an exemption shall 115
provide the health care provider or health care provider group 116
with both of the following: 117

(i) The information it relied upon in making its 118
determination; 119

(ii) A plain language explanation of how to appeal the 120
decision. 121

(4) A corporation shall not evaluate a health care 122
provider's or health care provider group's exemption relating to 123
a particular service or device more than once every twelve 124
months. 125

(5) Nothing in this section shall be construed as 126
requiring a corporation to evaluate an existing exemption. 127

(G) If an exemption is revoked and not appealed, the 128
exemption shall remain in effect until thirty days after the 129
date the corporation notifies the health care provider or health 130

care provider group of the corporation's decision to revoke the 131
exemption. 132

(H) A health care provider or health care provider group 133
may appeal the revocation of an exemption within thirty days of 134
receiving notice of the revocation. If the provider or provider 135
group appeals the revocation and the revocation is upheld, the 136
exemption remains in effect until five days after the date the 137
revocation is upheld. 138

(I) A decision to revoke or deny an exemption shall only 139
be made by a health care provider licensed in this state who 140
practices the same or a similar specialty as the health care 141
provider or health care provider group being considered for an 142
exemption and who has experience in providing the service or 143
device to which the exemption or potential exemption applies. 144

(J) Nothing in this section shall be construed as 145
prohibiting a health insuring corporation from making an 146
administrative denial of a claim. 147

Sec. 1751.723. (A) A series of violations of section 148
1751.721 or 1751.722 of the Revised Code that, taken together, 149
constitute a practice or pattern shall be considered an unfair 150
and deceptive practice under sections 3901.19 to 3901.26 of the 151
Revised Code. 152

(B) Notwithstanding division (F) of section 121.95 of the 153
Revised Code, the superintendent of insurance may adopt rules as 154
necessary to carry out the requirements of sections 1751.721 to 155
1751.723 of the Revised Code. 156

Sec. 3923.042. (A) A sickness and accident insurer that 157
applies a prior authorization requirement shall do both of the 158
following: 159

(1) Make prior authorization data available on its public web site in a readily accessible format and update the data not later than the first day of April annually; 160
161
162

(2) Submit prior authorization data to the superintendent of insurance not later than the first day of April annually. 163
164

(B) The data shall include all of the following information: 165
166

(1) The specialty of the health care provider requesting the prior authorization; 167
168

(2) Whether the prior authorization is for a medical service, a medical device, or a drug; 169
170

(3) The indication for use of the service, device, or drug under the prior authorization; 171
172

(4) If the prior authorization request was denied, the reason for the denial; 173
174

(5) If the approval or denial of a prior authorization request was appealed and the result of the appeal; 175
176

(6) The amount of time between the submission of a prior authorization request and the response from the insurer. 177
178

Sec. 3923.043. (A) (1) If a sickness and accident insurer has a prior authorization requirement for a health care service or medical device, the insurer shall not require a health care provider or health care provider group to comply with the requirement for that health care service or device if both of the following criteria are met: 179
180
181
182
183
184

(a) The insurer approved or would have approved at least ninety-five per cent of the prior authorization requests 185
186

submitted by the health care provider or health care provider 187
group for that service or device during the previous twelve- 188
month period. 189

(b) The health care provider or health care provider group 190
submitted at least twenty prior authorization requests for that 191
service or device to the sickness and accident insurer during 192
that twelve-month period. 193

(2) Such an exemption shall be provided for not less than 194
twelve months. 195

(3) An exemption under division (A) of this section shall 196
not be granted regarding a prior authorization requirement for a 197
drug. 198

(4) Nothing in this section shall be construed as 199
prohibiting an insurer from establishing an exemption period of 200
more than twelve months. 201

(B) (1) A health care provider or health care provider 202
group that does not receive an exemption under division (A) of 203
this section may request that the sickness and accident insurer 204
provide evidence to the provider or provider group supporting 205
its decision to not grant an exemption. 206

(2) The health care provider or health care provider group 207
may make the request at any time, but it may make not more than 208
one such request for the same service or device in a calendar 209
year. 210

(3) A sickness and accident insurer shall comply with such 211
a request. 212

(C) A health care provider or health care provider group 213
may appeal a sickness and accident insurer's decision to deny an 214

<u>exemption.</u>	215
<u>(D) A sickness and accident insurer shall not do either of</u>	216
<u>the following:</u>	217
<u>(1) Require a health care provider or health care provider</u>	218
<u>group to request an exemption provided under division (A) of</u>	219
<u>this section;</u>	220
<u>(2) Deny or reduce payment for a health care service or</u>	221
<u>medical device that was provided without prior authorization</u>	222
<u>pursuant to an exemption granted under division (A) of this</u>	223
<u>section on the sole basis that the service or device was</u>	224
<u>provided by or supervised by a health care provider or health</u>	225
<u>care provider group that is different than the provider or</u>	226
<u>provider group that requested the exemption. This division does</u>	227
<u>not apply if the providing or supervising provider or provider</u>	228
<u>group does either of the following:</u>	229
<u>(a) Knowingly and materially misrepresents the health care</u>	230
<u>service or medical device provided in its request for payment</u>	231
<u>from the sickness and accident insurer with the intent to obtain</u>	232
<u>an unlawful payment amount from the sickness and accident</u>	233
<u>insurer;</u>	234
<u>(b) Fails to substantially perform the health care service</u>	235
<u>or to provide the medical device.</u>	236
<u>(E) When an exemption is granted under division (A) of</u>	237
<u>this section for a health care service or medical device, the</u>	238
<u>sickness and accident insurer shall notify the health care</u>	239
<u>provider or health care provider group in question. The notice</u>	240
<u>shall be in writing and include all of the following</u>	241
<u>information:</u>	242
<u>(1) A statement that the health care provider or health</u>	243

<u>care provider group qualifies for an exemption to a prior</u>	244
<u>authorization requirement;</u>	245
<u>(2) The health care service or medical device to which the</u>	246
<u>exemption applies;</u>	247
<u>(3) The dates the exemption will begin and end.</u>	248
<u>(F)(1) At the end of the exemption period, a sickness and</u>	249
<u>accident insurer may evaluate an exemption it has granted under</u>	250
<u>division (A) of this section.</u>	251
<u>(2)(a) An insurer conducting such an evaluation shall</u>	252
<u>review twenty claims submitted to the insurer, selected at</u>	253
<u>random, for the health care service or medical device in</u>	254
<u>question.</u>	255
<u>(b) The reviewed claims shall be from the immediately</u>	256
<u>preceding three months. If there are not twenty relevant claims</u>	257
<u>in the preceding three months, the insurer may review earlier</u>	258
<u>claims.</u>	259
<u>(3)(a) If less than ninety-five per cent of the reviewed</u>	260
<u>claims would have been approved based on medical necessity, then</u>	261
<u>the insurer may revoke the exemption provided under division (A)</u>	262
<u>of this section.</u>	263
<u>(b) An insurer that is revoking an exemption shall provide</u>	264
<u>the health care provider or health care provider group with both</u>	265
<u>of the following:</u>	266
<u>(i) The information it relied upon in making its</u>	267
<u>determination;</u>	268
<u>(ii) A plain language explanation of how to appeal the</u>	269
<u>decision.</u>	270

(4) An insurer shall not evaluate a health care provider's 271
or health care provider group's exemption relating to a 272
particular service or device more than once every twelve months. 273

(5) Nothing in this section shall be construed as 274
requiring an insurer to evaluate an existing exemption. 275

(G) If an exemption is revoked and not appealed, the 276
exemption shall remain in effect until thirty days after the 277
date the sickness and accident insurer notifies the health care 278
provider or health care provider group of the insurer's decision 279
to revoke the exemption. 280

(H) A health care provider or health care provider group 281
may appeal the revocation of an exemption within thirty days 282
after receiving notification of the revocation. If the provider 283
or provider group appeals a revocation and the revocation is 284
upheld, the exemption remains in effect until five days after 285
the date the revocation is upheld. 286

(I) A decision to revoke or deny an exemption shall only 287
be made by a health care provider licensed in this state who 288
practices the same or a similar specialty as the health care 289
provider or health care provider group being considered for an 290
exemption and who has experience in providing the service or 291
device to which the exemption or potential exemption applies. 292

(J) Nothing in this section shall be construed as 293
prohibiting a sickness and accident insurer from making an 294
administrative denial of a claim. 295

Sec. 3923.044. (A) A series of violations of section 296
3923.042 or 3923.043 of the Revised Code that, taken together, 297
constitute a practice or pattern shall be considered an unfair 298
and deceptive practice under sections 3901.19 to 3901.26 of the 299

<u>Revised Code.</u>	300
<u>(B) Notwithstanding division (F) of section 121.95 of the Revised Code, the superintendent of insurance may adopt rules as necessary to carry out the requirements of sections 3923.042 to 3923.044 of the Revised Code.</u>	301 302 303 304
Sec. 5160.34. (A) As used in this section <u>sections 5160.34 to 5160.342 of the Revised Code:</u>	305 306
(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.	307 308 309 310
(2) "Clinical peer" means a health care provider in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.	311 312 313
(3) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.	314 315
(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, <u>medical device</u> , or drug.	316 317 318 319 320 321 322 323 324 325
(5) "Urgent care services" means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is	326 327 328

either of the following: 329

(a) Could seriously jeopardize the life, health, or safety 330
of the recipient or others due to the recipient's psychological 331
state; 332

(b) In the opinion of a practitioner with knowledge of the 333
recipient's medical or behavioral condition, would subject the 334
recipient to adverse health consequences without the care or 335
treatment that is the subject of the request. 336

(6) "Utilization review" ~~and "utilization review-~~ 337
~~organization" have~~ has the same ~~meanings-meaning~~ as in section 338
1751.77 of the Revised Code. 339

(B) If a medical assistance program has a prior 340
authorization requirement, the department of medicaid or its 341
designee, including a medicaid managed care organization, shall 342
do all of the following: 343

(1) On or before January 1, 2018, permit a health care 344
provider to access the prior authorization form through the 345
applicable electronic software system. 346

(2) (a) On or before January 1, 2018, permit the department 347
or its designee to accept and respond to prior prescription 348
benefit authorization requests through a secure electronic 349
transmission. 350

(b) On or before January 1, 2018, the department or its 351
designee shall accept and respond to prior prescription benefit 352
authorization requests through a secure electronic transmission 353
using NCPDP SCRIPT standard ePA transactions, and for prior 354
medical benefit authorization requests through a secure 355
electronic transmission using standards established by the 356
council for affordable quality health care on operating rules 357

for information exchange or its successor. 358

(c) For purposes of division (B)(2) of this section, 359
neither of the following shall be considered a secure electronic 360
transmission: 361

(i) A facsimile; 362

(ii) A proprietary payer portal for prescription drug 363
requests that does not use NCPDP SCRIPT standard. 364

(3) On or before January 1, 2018, a health care provider 365
and the department of medicaid or its designee may enter into a 366
contractual arrangement under which the department or its 367
designee agrees to process prior authorization requests that are 368
not submitted electronically because of the financial hardship 369
that electronic submission of prior authorization requests would 370
create for the provider or if internet connectivity is limited 371
or unavailable where the provider is located. 372

(4)(a) On or before January 1, 2018, if the health care 373
provider submits the request for prior authorization 374
electronically as described in divisions (B)(1) and (2) of this 375
section, the department or its designee shall respond to all 376
prior authorization requests within forty-eight hours for urgent 377
care services, or ten calendar days for any prior authorization 378
request that is not for an urgent care service, of the time the 379
request is received by the department or its designee. Division 380
(B)(4) of this section does not apply to emergency services. 381

(b) The response required under division (B)(4)(a) of this 382
section shall indicate whether the request is approved or 383
denied. If the prior authorization is denied, the department or 384
its designee shall provide the specific reason for the denial. 385

(c) If the prior authorization request is incomplete, the 386

department or its designee shall indicate the specific 387
additional information that is required to process the request. 388

(5) (a) On or before January 1, 2018, if a health care 389
provider submits a prior authorization request as described in 390
divisions (B) (1) and (2) of this section, the department or its 391
designee shall provide an electronic receipt to the health care 392
provider acknowledging that the prior authorization request was 393
received. 394

(b) On or before January 1, 2018, if the department or its 395
designee requests additional information that is required to 396
process a prior authorization request as described in division 397
(B) (4) (c) of this section, the health care provider shall 398
provide an electronic receipt to the department or its designee 399
acknowledging that the request for additional information was 400
received. 401

(6) (a) On or before January 1, 2017, honor a prior 402
authorization approval for an approved drug for the lesser of 403
the following from the date of approval: 404

(i) Twelve months; 405

(ii) The last day of the medical assistance recipient's 406
eligibility for the medical assistance program. 407

(b) The duration of all other prior authorization 408
approvals shall be dictated by the medical assistance program. 409

(c) The department or its designee, in relation to prior 410
approval under division (B) (6) (a) of this section, may require a 411
health care provider to submit information to the department or 412
its designee indicating that the patient's chronic condition has 413
not changed. 414

(i) The request for information by the department or its designee and the response by the health care provider shall be in an electronic format, which may be by electronic mail or other electronic communication.

(ii) The frequency of the submission of requested information shall be consistent with medical or scientific evidence as defined in section 3922.01 of the Revised Code, but shall not be required more frequently than quarterly.

(iii) If the health care provider does not respond within five calendar days from the date the request was received, the insurer or plan may terminate the twelve-month approval.

(d) A twelve-month 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.

(e) A twelve-month approval provided under division (B) (6) (a) of this section does not apply to and is not required for any of the following:

(i) Medications that are prescribed for a non-maintenance condition;

(ii) Medications that have a typical treatment of less than one year;

(iii) Medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year, or greater, prior authorization period will be given;

(iv) Medications where there is medical or scientific

evidence as defined in section 3922.01 of the Revised Code that 443
do not support a twelve-month prior approval; 444

(v) Medications that are a schedule I or II controlled 445
substance or any opioid analgesic or benzodiazepine, as defined 446
in section 3719.01 of the Revised Code; 447

(vi) Medications that are not prescribed by an in-network 448
provider as part of a care management program. 449

(7) On or before January 1, 2017, the department or its 450
designee may, but is not required to, provide the twelve-month 451
approval prescribed in division (B) (6) (a) of this section for a 452
prescription drug that meets either of the following: 453

(a) The drug is prescribed or administered to treat a rare 454
medical condition and pursuant to medical or scientific evidence 455
as defined in section 3922.01 of the Revised Code. 456

(b) Medications that are controlled substances not 457
included in division (B) (6) (e) (v) of this section. 458

For purposes of division (B) (7) of this section, "rare 459
medical condition" means any disease or condition that affects 460
fewer than two-hundred thousand individuals in the United 461
States. 462

(8) Nothing in division (B) (6) or (7) of this section 463
prohibits the substitution, in accordance with section 4729.38 464
of the Revised Code, of any drug that has received a twelve- 465
month approval under division (B) (6) (a) of this section when 466
there is a release of either of the following: 467

(a) A United States food and drug administration approved 468
comparable brand product or a generic counterpart of a brand 469
product that is listed as therapeutically equivalent in the 470

United States food and drug administration's publication titled 471
approved drug products with therapeutic equivalence evaluations; 472

(b) An interchangeable biological product, as defined in 473
section 3715.01 of the Revised Code. 474

(9) (a) On or after January 1, 2017, upon written request, 475
the department or its designee shall permit a retrospective 476
review for a claim that is submitted for a service where prior 477
authorization was required, but not obtained if the service in 478
question meets all of the following: 479

(i) The service is directly related to another service for 480
which prior approval has already been obtained and that has 481
already been performed. 482

(ii) The new service was not known to be needed at the 483
time the original prior authorized service was performed. 484

(iii) The need for the new service was revealed at the 485
time the original authorized service was performed. 486

(b) Once the written request and all necessary information 487
is received, the department or its designee shall review the 488
claim for coverage and medical necessity. The department or its 489
designee shall not deny a claim for such a new service based 490
solely on the fact that a prior authorization approval was not 491
received for the new service in question. 492

(10) (a) On or before January 1, 2017, disclose to all 493
participating health care providers any new prior authorization 494
requirement at least thirty days prior to the effective date of 495
the new requirement. 496

(b) The notice may be sent via electronic mail or standard 497
mail and shall be conspicuously entitled "Notice of Changes to 498

Prior Authorization Requirements." The notice is not required to 499
contain a complete listing of all changes made to the prior 500
authorization requirements, but shall include specific 501
information on where the health care provider may locate the 502
information on the department's or its designee's web site or, 503
if applicable, the department's or its designee's portal. 504

(c) All participating health care providers shall promptly 505
notify the department or its designee of any changes to the 506
health care provider's electronic mail or standard mail address. 507

(11) (a) On or before January 1, 2017, make available to 508
all participating health care providers on its web site or 509
provider portal a listing of its prior authorization 510
requirements, including specific information or documentation 511
that a provider must submit in order for the prior authorization 512
request to be considered complete. 513

(b) Make available on its web site information about the 514
medical assistance programs offered in this state that clearly 515
identifies specific services, drugs, or devices to which a prior 516
authorization requirement exists. 517

(12) On or before January 1, 2018, establish a streamlined 518
appeal process relating to adverse prior authorization 519
determinations that shall include all of the following: 520

(a) For urgent care services, the appeal shall be 521
considered within forty-eight hours after the department or its 522
designee receives the appeal. 523

(b) For all other matters, the appeal shall be considered 524
within ten calendar days after the department or its designee 525
receives the appeal. 526

(c) The appeal shall be between the health care provider 527

requesting the service in question and a clinical peer appointed 528
by or contracted by the department or the department's designee. 529

(d) If the appeal does not resolve the disagreement, the 530
appeal procedures shall permit the recipient to further appeal 531
in accordance with section 5160.31 of the Revised Code. 532

(C) Beginning January 1, 2017, except in cases of 533
fraudulent or materially incorrect information, the department 534
or its designee shall not retroactively deny a prior 535
authorization for a health care service, drug, or device when 536
all of the following are met: 537

(1) The health care provider submits a prior authorization 538
request to the department or its designee for a health care 539
service, drug, or device. 540

(2) The department or its designee approves the prior 541
authorization request after determining that all of the 542
following are true: 543

(a) The recipient is eligible for the health care service, 544
drug, or device under the medical assistance program. 545

(b) The health care service, drug, or device is covered by 546
the medical assistance program. 547

(c) The health care service, drug, or device meets the 548
department's standards for medical necessity and prior 549
authorization. 550

(3) The health care provider renders the health care 551
service, drug, or device pursuant to the approved prior 552
authorization request and all of the terms and conditions of the 553
health care provider's contract with the department or the 554
department's designee. 555

(4) On the date the health care provider renders the prior approved health care service, drug, or device, all of the following are true:

(a) The recipient is eligible for the medical assistance program.

(b) The recipient's condition or circumstances related to the recipient's care has not changed.

(c) The health care provider submits an accurate claim that matches the information submitted by the health care provider in the approved prior authorization request.

(5) If the health care provider submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care provider in the approved prior authorization request, upon receiving a denial of services from the department or its designee, the health care provider may resubmit the claim pursuant to division (C) of this section with the information that matches the information included in the approved prior authorization.

(D) Any provision of a contractual arrangement entered into between the department or its designee and a health care provider or recipient that is contrary to divisions (A) to (C) of this section is unenforceable.

(E) The director of medicaid may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the provisions of this section and section 5160.342 of the Revised Code.

Sec. 5160.341. (A) If the department or its designee applies a prior authorization requirement, it shall make prior

authorization data available on its public web site in a readily 585
accessible format and update the data not later than the first 586
day of April annually. 587

(B) The data shall include all of the following 588
information: 589

(1) The specialty of the health care provider requesting 590
the prior authorization; 591

(2) Whether the prior authorization is for a health care 592
service, a medical device, or a drug; 593

(3) The indication for use of the service, device, or drug 594
under the prior authorization; 595

(4) If the prior authorization request was denied, the 596
reason for the denial; 597

(5) If the approval or denial of a prior authorization 598
request was appealed and the result of the appeal; 599

(6) The amount of time between the submission of a prior 600
authorization request and the response from the department or 601
its designee. 602

Sec. 5160.342. (A) (1) If a medical assistance program has 603
a prior authorization requirement for a health care service or 604
medical device, the department or its designee shall not require 605
a health care provider or health care provider group to comply 606
with the requirement for that health care service or device if 607
both of the following criteria are met: 608

(a) The department of medicaid or its designee approved or 609
would have approved at least ninety-five per cent of the prior 610
authorization requests submitted by the health care provider or 611
health care provider group for that service or device during the 612

previous twelve-month period. 613

(b) The health care provider or health care provider group 614
submitted at least twenty prior authorization requests for that 615
service or device to the department or its designee during that 616
twelve-month period. 617

(2) Such an exemption shall be provided for not less than 618
twelve months. 619

(3) An exemption under division (A) of this section shall 620
not be granted regarding a prior authorization requirement for a 621
drug. 622

(4) Nothing in this section shall be construed as 623
prohibiting the department or its designee from establishing an 624
exemption period of more than twelve months. 625

(B) (1) A health care provider or health care provider 626
group that does not receive an exemption under division (A) of 627
this section may request that the department or the department's 628
designee provide evidence to the provider or provider group 629
supporting its decision to not grant an exemption. 630

(2) The health care provider or health care provider group 631
may make such a request at any time, but it may make not more 632
than one such request for the same service or device in a 633
calendar year. 634

(3) The department or its designee shall comply with such 635
a request. 636

(C) A health care provider or health care provider group 637
may appeal the department or its designee's decision to deny an 638
exemption. 639

(D) The department or its designee shall not do either of 640

the following: 641

(1) Require a health care provider or health care provider group to request an exemption provided under division (A) of this section; 642
643
644

(2) Deny or reduce payment for a health care service or medical device that was provided without prior authorization pursuant to an exemption granted under division (A) of this section on the sole basis that the service or device was provided by or supervised by a health care provider or health care provider group that is different than the provider or provider group that requested the exemption. This division does not apply if the providing or supervising provider or provider group does either of the following: 645
646
647
648
649
650
651
652
653

(a) Knowingly and materially misrepresents the health care service or medical device provided in its request for payment from the department or the department's designee with the intent to obtain an unlawful payment amount from the department or its designee; 654
655
656
657
658

(b) Fails to substantially perform the health care service or to provide the medical device. 659
660

(E) When an exemption is granted under division (A) of this section for a health care service or medical device, the department or its designee shall notify the health care provider or health care provider group in question. The notice shall include all of the following information: 661
662
663
664
665

(1) A statement that the health care provider or health care provider group qualifies for an exemption to a prior authorization requirement; 666
667
668

(2) The health care service or medical device to which the 669

exemption applies; 670

(3) The dates the exemption will begin and end. 671

(F) (1) At the end of the exemption period, the department
or its designee may evaluate an exemption it has granted under
division (A) of this section. 672
673
674

(2) (a) When conducting such an evaluation, the department
or its designee shall review twenty claims submitted to the
department or its designee, selected at random, for the health
care service or medical device in question. 675
676
677
678

(b) The reviewed claims shall be from the immediately
preceding three months. If there are not twenty relevant claims
in the preceding three months, the department or its designee
may review earlier claims. 679
680
681
682

(3) (a) If less than ninety-five per cent of the reviewed
claims would have been approved based on medical necessity, then
the department or its designee may revoke the exemption provided
under division (A) of this section. 683
684
685
686

(b) If the department or its designee revokes an
exemption, it shall provide the health care provider or health
care provider group with both of the following: 687
688
689

(i) The information it relied upon in making its
determination; 690
691

(ii) A plain language explanation of how to appeal the
decision. 692
693

(4) The department or its designee shall not evaluate a
health care provider's or health care provider group's exemption
relating to a particular service or device more than once every
twelve months. 694
695
696
697

(5) Nothing in this section shall be construed as 698
requiring the department or its designee to evaluate an existing 699
exemption. 700

(G) If an exemption is revoked and not appealed, the 701
exemption shall remain in effect until thirty days after the 702
date the department or its designee notifies the health care 703
provider or health care provider group of the department or its 704
designee's decision to revoke the exemption. 705

(H) A health care provider or health care provider group 706
may appeal the revocation of an exemption within thirty days of 707
receiving notice of the revocation. If the provider or provider 708
group appeals the revocation and the revocation is upheld, the 709
exemption remains in effect until five days after the date the 710
revocation is upheld. 711

(I) A decision to revoke or deny an exemption shall only 712
be made by a health care provider licensed in this state who 713
practices the same or a similar specialty as the health care 714
provider or health care provider group being considered for an 715
exemption and who has experience in providing the service or 716
device to which the exemption or potential exemption applies. 717

(J) Nothing in this section shall be construed as 718
prohibiting the department or its designee from making an 719
administrative denial of a claim. 720

Section 2. That existing section 5160.34 of the Revised 721
Code is hereby repealed. 722